

12100

## CERTIFICATE OF DEATH

12014

Reg. Dist. No.

|  |                                  |   |   |   |   |   |  |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>P.O. 2, Cumberland Md.</u>  |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>P.O. 2, Cumberland, Md</u>                           |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>P.O. 2 Baltimore Pike</u>   |                                  |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Carol</u> Middle <u>Esther</u> Last <u>Coker</u>  |                                  |   |   | 4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1959</u>   |   |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 28, 1901</u> | 9. AGE (In years lost birthday) <u>58</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Months Days Hours Min.            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Chillicothe, Missouri</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>       |  |
| 13. FATHER'S NAME<br><u>John Hawkins</u>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Iida Church</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |   | 17. INFORMANT Address<br><u>Esther J. Coker, P.O. 2, Cumberland, Md.</u>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Arterio Sclerotic vas.</u><br>(c) <u>Since 1949.</u> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Very short</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>  |                                  |   |   |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                  |  |
| 21. I certify that I attended the deceased from <u>Nov 25, 1949</u> to <u>11-5-1959</u> , that I last saw the deceased alive on <u>10-30-1959</u> , and that death occurred at <u>1:15 P.</u> M., from the causes and on the date stated above.  |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <u>Wm. A. Williams</u>  |                                  |   |   | ADDRESS (Street, city or town, state)<br><u>Cumberland, Md.</u>   |   | DATE SIGNED<br><u>11-6-59</u>                         |  |
| PHYSICIAN'S NAME (Type)  |                                  |   |   |   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |                                  | 22b. DATE THEREOF   |   | 22c. NAME OF CEMETERY OR CREMATORY  |   | 22d. LOCATION (City, town, or county) (State)         |  |
| <u>Cremation</u>   |                                  | <u>11/9/1959</u>  |   | <u>L. Beinhauer Cemetery</u>  |   | <u>Pittsburgh Penna.</u>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Louis Stern Inc.</u>  |                                  |   |   | ADDRESS<br><u>Cumb. Md.</u>   |   | 24b. REC'D BY REGISTRAR<br>DATE <u>NOV 12 '59</u>     |  |
|  |                                  |   |   |   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur E. Hanks</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12014

CERTIFICATE OF DEATH

1210

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Page 2 of 2

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br><i>John Doe</i>                     |  | 2. SEX<br><i>Male</i>   |  |
| 3. DATE OF BIRTH<br><i>Jan 1, 1900</i>                     |  | 4. PLACE OF BIRTH<br><i>Baltimore, Md.</i>                    |  |
| 5. OCCUPATION<br><i>Teacher</i>                            |  | 6. CAUSE OF DEATH<br><i>Heart Disease</i>                     |  |
| 7. DATE OF DEATH<br><i>Dec 15, 1950</i>                    |  | 8. PLACE OF DEATH<br><i>Home</i>                              |  |
| 9. SIGNATURE OF DECEASED<br><i>John Doe</i>                |  | 10. SIGNATURE OF WITNESS<br><i>John Doe</i>                   |  |
| 11. SIGNATURE OF PHYSICIAN<br><i>John Doe</i>              |  | 12. SIGNATURE OF REGISTRAR<br><i>John Doe</i>                 |  |
| 13. SIGNATURE OF CLERK<br><i>John Doe</i>                  |  | 14. SIGNATURE OF JUDGE<br><i>John Doe</i>                     |  |
| 15. SIGNATURE OF SHERIFF<br><i>John Doe</i>                |  | 16. SIGNATURE OF CORONER<br><i>John Doe</i>                   |  |
| 17. SIGNATURE OF DISTRICT ATTORNEY<br><i>John Doe</i>      |  | 18. SIGNATURE OF COUNTY CLERK<br><i>John Doe</i>              |  |
| 19. SIGNATURE OF STATE CLERK<br><i>John Doe</i>            |  | 20. SIGNATURE OF SECRETARY<br><i>John Doe</i>                 |  |
| 21. SIGNATURE OF ASSISTANT SECRETARY<br><i>John Doe</i>    |  | 22. SIGNATURE OF CHIEF CLERK<br><i>John Doe</i>               |  |
| 23. SIGNATURE OF DEPUTY CLERK<br><i>John Doe</i>           |  | 24. SIGNATURE OF RECORDS CLERK<br><i>John Doe</i>             |  |
| 25. SIGNATURE OF FILE CLERK<br><i>John Doe</i>             |  | 26. SIGNATURE OF INDEX CLERK<br><i>John Doe</i>               |  |
| 27. SIGNATURE OF RESEARCH CLERK<br><i>John Doe</i>         |  | 28. SIGNATURE OF ASSISTANT RESEARCH CLERK<br><i>John Doe</i>  |  |
| 29. SIGNATURE OF CLERICAL ASSISTANT<br><i>John Doe</i>     |  | 30. SIGNATURE OF OFFICE ASSISTANT<br><i>John Doe</i>          |  |
| 31. SIGNATURE OF RECEPTIONIST<br><i>John Doe</i>           |  | 32. SIGNATURE OF MAIL ROOM CLERK<br><i>John Doe</i>           |  |
| 33. SIGNATURE OF TELEPHONE ROOM CLERK<br><i>John Doe</i>   |  | 34. SIGNATURE OF JANITOR<br><i>John Doe</i>                   |  |
| 35. SIGNATURE OF GROUNDKEEPER<br><i>John Doe</i>           |  | 36. SIGNATURE OF SECURITY GUARD<br><i>John Doe</i>            |  |
| 37. SIGNATURE OF NIGHT WATCHMAN<br><i>John Doe</i>         |  | 38. SIGNATURE OF PORTER<br><i>John Doe</i>                    |  |
| 39. SIGNATURE OF CLEANER<br><i>John Doe</i>                |  | 40. SIGNATURE OF COOK<br><i>John Doe</i>                      |  |
| 41. SIGNATURE OF BUTLER<br><i>John Doe</i>                 |  | 42. SIGNATURE OF HOUSEKEEPER<br><i>John Doe</i>               |  |
| 43. SIGNATURE OF GARDENER<br><i>John Doe</i>               |  | 44. SIGNATURE OF PAINTER<br><i>John Doe</i>                   |  |
| 45. SIGNATURE OF CARPENTER<br><i>John Doe</i>              |  | 46. SIGNATURE OF ELECTRICIAN<br><i>John Doe</i>               |  |
| 47. SIGNATURE OF PLUMBER<br><i>John Doe</i>                |  | 48. SIGNATURE OF ROOFER<br><i>John Doe</i>                    |  |
| 49. SIGNATURE OF TILER<br><i>John Doe</i>                  |  | 50. SIGNATURE OF PAVER<br><i>John Doe</i>                     |  |
| 51. SIGNATURE OF CONCRETE FINISHER<br><i>John Doe</i>      |  | 52. SIGNATURE OF WOODWORKER<br><i>John Doe</i>                |  |
| 53. SIGNATURE OF METALWORKER<br><i>John Doe</i>            |  | 54. SIGNATURE OF GLASSWORKER<br><i>John Doe</i>               |  |
| 55. SIGNATURE OF JEWELRY MAKER<br><i>John Doe</i>          |  | 56. SIGNATURE OF WATCHMAKER<br><i>John Doe</i>                |  |
| 57. SIGNATURE OF OPTICIAN<br><i>John Doe</i>               |  | 58. SIGNATURE OF DENTIST<br><i>John Doe</i>                   |  |
| 59. SIGNATURE OF VETERINARIAN<br><i>John Doe</i>           |  | 60. SIGNATURE OF PHARMACEUTICIAN<br><i>John Doe</i>           |  |
| 61. SIGNATURE OF NURSE<br><i>John Doe</i>                  |  | 62. SIGNATURE OF PHYSICIAN<br><i>John Doe</i>                 |  |
| 63. SIGNATURE OF SURGEON<br><i>John Doe</i>                |  | 64. SIGNATURE OF OBSTETRICIAN<br><i>John Doe</i>              |  |
| 65. SIGNATURE OF GYN. & OBST. ASSISTANT<br><i>John Doe</i> |  | 66. SIGNATURE OF MIDWIFE<br><i>John Doe</i>                   |  |
| 67. SIGNATURE OF DENTIST ASSISTANT<br><i>John Doe</i>      |  | 68. SIGNATURE OF OPTICIAN ASSISTANT<br><i>John Doe</i>        |  |
| 69. SIGNATURE OF JEWELRY ASSISTANT<br><i>John Doe</i>      |  | 70. SIGNATURE OF WATCHMAKER ASSISTANT<br><i>John Doe</i>      |  |
| 71. SIGNATURE OF OPTICIAN ASSISTANT<br><i>John Doe</i>     |  | 72. SIGNATURE OF DENTIST ASSISTANT<br><i>John Doe</i>         |  |
| 73. SIGNATURE OF VETERINARIAN ASSISTANT<br><i>John Doe</i> |  | 74. SIGNATURE OF PHARMACEUTICIAN ASSISTANT<br><i>John Doe</i> |  |
| 75. SIGNATURE OF NURSE ASSISTANT<br><i>John Doe</i>        |  | 76. SIGNATURE OF PHYSICIAN ASSISTANT<br><i>John Doe</i>       |  |
| 77. SIGNATURE OF SURGEON ASSISTANT<br><i>John Doe</i>      |  | 78. SIGNATURE OF OBSTETRICIAN ASSISTANT<br><i>John Doe</i>    |  |
| 79. SIGNATURE OF GYN. & OBST. ASSISTANT<br><i>John Doe</i> |  | 80. SIGNATURE OF MIDWIFE ASSISTANT<br><i>John Doe</i>         |  |
| 81. SIGNATURE OF DENTIST ASSISTANT<br><i>John Doe</i>      |  | 82. SIGNATURE OF OPTICIAN ASSISTANT<br><i>John Doe</i>        |  |
| 83. SIGNATURE OF JEWELRY ASSISTANT<br><i>John Doe</i>      |  | 84. SIGNATURE OF WATCHMAKER ASSISTANT<br><i>John Doe</i>      |  |
| 85. SIGNATURE OF OPTICIAN ASSISTANT<br><i>John Doe</i>     |  | 86. SIGNATURE OF DENTIST ASSISTANT<br><i>John Doe</i>         |  |
| 87. SIGNATURE OF VETERINARIAN ASSISTANT<br><i>John Doe</i> |  | 88. SIGNATURE OF PHARMACEUTICIAN ASSISTANT<br><i>John Doe</i> |  |
| 89. SIGNATURE OF NURSE ASSISTANT<br><i>John Doe</i>        |  | 90. SIGNATURE OF PHYSICIAN ASSISTANT<br><i>John Doe</i>       |  |
| 91. SIGNATURE OF SURGEON ASSISTANT<br><i>John Doe</i>      |  | 92. SIGNATURE OF OBSTETRICIAN ASSISTANT<br><i>John Doe</i>    |  |
| 93. SIGNATURE OF GYN. & OBST. ASSISTANT<br><i>John Doe</i> |  | 94. SIGNATURE OF MIDWIFE ASSISTANT<br><i>John Doe</i>         |  |
| 95. SIGNATURE OF DENTIST ASSISTANT<br><i>John Doe</i>      |  | 96. SIGNATURE OF OPTICIAN ASSISTANT<br><i>John Doe</i>        |  |
| 97. SIGNATURE OF JEWELRY ASSISTANT<br><i>John Doe</i>      |  | 98. SIGNATURE OF WATCHMAKER ASSISTANT<br><i>John Doe</i>      |  |
| 99. SIGNATURE OF OPTICIAN ASSISTANT<br><i>John Doe</i>     |  | 100. SIGNATURE OF DENTIST ASSISTANT<br><i>John Doe</i>        |  |

1. NAME OF DECEASED  
2. SEX  
3. DATE OF BIRTH  
4. PLACE OF BIRTH  
5. OCCUPATION  
6. CAUSE OF DEATH  
7. DATE OF DEATH  
8. PLACE OF DEATH  
9. SIGNATURE OF DECEASED  
10. SIGNATURE OF WITNESS  
11. SIGNATURE OF PHYSICIAN  
12. SIGNATURE OF REGISTRAR  
13. SIGNATURE OF CLERK  
14. SIGNATURE OF JUDGE  
15. SIGNATURE OF SHERIFF  
16. SIGNATURE OF CORONER  
17. SIGNATURE OF DISTRICT ATTORNEY  
18. SIGNATURE OF COUNTY CLERK  
19. SIGNATURE OF STATE CLERK  
20. SIGNATURE OF SECRETARY  
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93. SIGNATURE OF JEWELRY ASSISTANT  
94. SIGNATURE OF WATCHMAKER ASSISTANT  
95. SIGNATURE OF OPTICIAN ASSISTANT  
96. SIGNATURE OF DENTIST ASSISTANT  
97. SIGNATURE OF VETERINARIAN ASSISTANT  
98. SIGNATURE OF PHARMACEUTICIAN ASSISTANT  
99. SIGNATURE OF NURSE ASSISTANT  
100. SIGNATURE OF PHYSICIAN ASSISTANT

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12015

Reg. Dist. No.

12101

|   |                                  |   |   |   |  |   |  |
|---|----------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Cumberland</u>   |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural Cumberland</u>                                 |  | d. STREET ADDRESS<br><u>RFD #3 Valley Rd.</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>RFD #3 Valley Rd.</u>  |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MILLARD</u> Middle <u>E.</u> Last <u>BARTLETT</u>   |                                  |   |   | 4. DATE OF DEATH<br>Month <u>November</u> Day <u>2</u> Year <u>1959</u>   |  |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 16, 1895</u> | 9. AGE (In years last birthday)<br><u>64</u> yrs.   | IF UNDER 1 YEAR<br>Months <u></u> Days <u></u> | IF UNDER 24 HRS.<br>Hours <u></u> Min. <u></u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farmer</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>James B Bartlett</u>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><u>Polly Ann Channel</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><u>Mrs. Vera E. Graham, Cumberland, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br><u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,<br>(b) <u>Advanced Arteriosclerotic disease</u><br>DUE TO<br>(c) <u></u>   |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><br><u>---</u>                               |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |   |   |   |  |   |  |
| ACTUAL SIGNATURE <u>Benedict Skitarellic</u> M.D.   |                                  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | DATE SIGNED   |  |
| EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u>  |                                  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |                                  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  | <u>Nov. 2, 1959</u>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>11/5/59</u>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Zion Memo. Rd.</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland Md</u>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Louis Allen Inc. Cumberland Md</u>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 6 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Hines</u>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WESTLAND STATE DEPARTMENT OF HEALTH - BATTLEMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                  |  |                                  |  |                                 |  |
|----------------------------------|--|----------------------------------|--|---------------------------------|--|
| 1. NAME OF DECEASED              |  | 2. SEX                           |  | 3. AGE                          |  |
| 4. OCCUPATION                    |  | 5. MARITAL STATUS                |  | 6. PLACE OF BIRTH               |  |
| 7. DATE OF DEATH                 |  | 8. TIME OF DEATH                 |  | 9. PLACE OF DEATH               |  |
| 10. CAUSE OF DEATH               |  | 11. MANNER OF DEATH              |  | 12. SIGNATURE OF EXAMINER       |  |
| 13. SIGNATURE OF WITNESS         |  | 14. SIGNATURE OF CORONER         |  | 15. SIGNATURE OF JURY           |  |
| 16. SIGNATURE OF DECEASED        |  | 17. SIGNATURE OF NEXT OF KIN     |  | 18. SIGNATURE OF FUNERAL HOME   |  |
| 19. SIGNATURE OF BURIAL SOCIETY  |  | 20. SIGNATURE OF CHURCH          |  | 21. SIGNATURE OF CEMETERY       |  |
| 22. SIGNATURE OF MINISTERS       |  | 23. SIGNATURE OF MUSICIANS       |  | 24. SIGNATURE OF FLORISTS       |  |
| 25. SIGNATURE OF COFFIN MAKERS   |  | 26. SIGNATURE OF CARRIAGE MAKERS |  | 27. SIGNATURE OF HEARSE DRIVERS |  |
| 28. SIGNATURE OF BURIAL SOCIETY  |  | 29. SIGNATURE OF CHURCH          |  | 30. SIGNATURE OF CEMETERY       |  |
| 31. SIGNATURE OF MINISTERS       |  | 32. SIGNATURE OF MUSICIANS       |  | 33. SIGNATURE OF FLORISTS       |  |
| 34. SIGNATURE OF COFFIN MAKERS   |  | 35. SIGNATURE OF CARRIAGE MAKERS |  | 36. SIGNATURE OF HEARSE DRIVERS |  |
| 37. SIGNATURE OF BURIAL SOCIETY  |  | 38. SIGNATURE OF CHURCH          |  | 39. SIGNATURE OF CEMETERY       |  |
| 40. SIGNATURE OF MINISTERS       |  | 41. SIGNATURE OF MUSICIANS       |  | 42. SIGNATURE OF FLORISTS       |  |
| 43. SIGNATURE OF COFFIN MAKERS   |  | 44. SIGNATURE OF CARRIAGE MAKERS |  | 45. SIGNATURE OF HEARSE DRIVERS |  |
| 46. SIGNATURE OF BURIAL SOCIETY  |  | 47. SIGNATURE OF CHURCH          |  | 48. SIGNATURE OF CEMETERY       |  |
| 49. SIGNATURE OF MINISTERS       |  | 50. SIGNATURE OF MUSICIANS       |  | 51. SIGNATURE OF FLORISTS       |  |
| 52. SIGNATURE OF COFFIN MAKERS   |  | 53. SIGNATURE OF CARRIAGE MAKERS |  | 54. SIGNATURE OF HEARSE DRIVERS |  |
| 55. SIGNATURE OF BURIAL SOCIETY  |  | 56. SIGNATURE OF CHURCH          |  | 57. SIGNATURE OF CEMETERY       |  |
| 58. SIGNATURE OF MINISTERS       |  | 59. SIGNATURE OF MUSICIANS       |  | 60. SIGNATURE OF FLORISTS       |  |
| 61. SIGNATURE OF COFFIN MAKERS   |  | 62. SIGNATURE OF CARRIAGE MAKERS |  | 63. SIGNATURE OF HEARSE DRIVERS |  |
| 64. SIGNATURE OF BURIAL SOCIETY  |  | 65. SIGNATURE OF CHURCH          |  | 66. SIGNATURE OF CEMETERY       |  |
| 67. SIGNATURE OF MINISTERS       |  | 68. SIGNATURE OF MUSICIANS       |  | 69. SIGNATURE OF FLORISTS       |  |
| 70. SIGNATURE OF COFFIN MAKERS   |  | 71. SIGNATURE OF CARRIAGE MAKERS |  | 72. SIGNATURE OF HEARSE DRIVERS |  |
| 73. SIGNATURE OF BURIAL SOCIETY  |  | 74. SIGNATURE OF CHURCH          |  | 75. SIGNATURE OF CEMETERY       |  |
| 76. SIGNATURE OF MINISTERS       |  | 77. SIGNATURE OF MUSICIANS       |  | 78. SIGNATURE OF FLORISTS       |  |
| 79. SIGNATURE OF COFFIN MAKERS   |  | 80. SIGNATURE OF CARRIAGE MAKERS |  | 81. SIGNATURE OF HEARSE DRIVERS |  |
| 82. SIGNATURE OF BURIAL SOCIETY  |  | 83. SIGNATURE OF CHURCH          |  | 84. SIGNATURE OF CEMETERY       |  |
| 85. SIGNATURE OF MINISTERS       |  | 86. SIGNATURE OF MUSICIANS       |  | 87. SIGNATURE OF FLORISTS       |  |
| 88. SIGNATURE OF COFFIN MAKERS   |  | 89. SIGNATURE OF CARRIAGE MAKERS |  | 90. SIGNATURE OF HEARSE DRIVERS |  |
| 91. SIGNATURE OF BURIAL SOCIETY  |  | 92. SIGNATURE OF CHURCH          |  | 93. SIGNATURE OF CEMETERY       |  |
| 94. SIGNATURE OF MINISTERS       |  | 95. SIGNATURE OF MUSICIANS       |  | 96. SIGNATURE OF FLORISTS       |  |
| 97. SIGNATURE OF COFFIN MAKERS   |  | 98. SIGNATURE OF CARRIAGE MAKERS |  | 99. SIGNATURE OF HEARSE DRIVERS |  |
| 100. SIGNATURE OF BURIAL SOCIETY |  | 101. SIGNATURE OF CHURCH         |  | 102. SIGNATURE OF CEMETERY      |  |



CHIEF CLERK



## CERTIFICATE OF DEATH

12016

Reg. Dist. No.

12086

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>43 Westernport</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>102 Cromer St.</b>  |  |   |  | e. STREET ADDRESS<br><b>102 Cromer St.</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth Louise</b> Middle <b>Beck</b> Last <b>Beck</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Nov</b> Day <b>27</b> Year <b>1959</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>April 26, 1887</b>  |  |
| 9. AGE (In years last birthday) yrs.<br><b>72</b>  |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> |  | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House work</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Wheeling, W.Va.</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  | 13. FATHER'S NAME<br><b>John Henry Beck</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Francis Geiger</b>  |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |  |  |
| 16. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br><b>Charles Beck Westernport, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Degeneration not specified 45 Rheumatic</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis and Myocardial</b><br>DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH 5 years</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>  |  |   |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| 20f. (City or town) (County) (State)   |  |   |  | 21. I certify that I attended the deceased from <b>Nov. 26, 1959</b> , to <b>Nov. 27, 1959</b> , that I last saw the deceased alive on <b>Nov. 26, 1959</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above. |  |  |  |
| ACTUAL SIGNATURE <b>Paul R. Wilson</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>111 Ashfield St. Piedmont, W.Va.</b> DATE SIGNED <b>11-27-59</b>   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Paul R. Wilson, M.D.</b>  |  |   |  | ADDRESS <b>Ashfield St. Piedmont, W.Va.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Nov. 29, 1959</b>                                     |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport Md.</b>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. A. Fullbrook Jr.</b>   |  |   |  | ADDRESS <b>Piedmont, W.Va.</b>  |  |  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 1 '59</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Harris</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12036

12036

|  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED<br>Robert St.                |  | 2. SEX<br>Male                                   |  | 3. AGE<br>38                                 |  | 4. DATE OF BIRTH<br>April 26, 1887               |  | 5. PLACE OF BIRTH<br>Westonport, Md.             |  | 6. OCCUPATION<br>Police Constable                |  |
| 7. MARITAL STATUS<br>Single                      |  | 8. COLOR<br>White                                |  | 9. HEIGHT<br>5' 8"                           |  | 10. WEIGHT<br>150 lbs.                           |  | 11. BUILD<br>Medium                              |  | 12. COMPLEXION<br>Fair                           |  |
| 13. EDUCATION<br>High School                     |  | 14. RELIGION<br>Roman Catholic                   |  | 15. MANNER OF DEATH<br>Natural               |  | 16. CAUSE OF DEATH<br>Heart Disease              |  | 17. DISEASE OR INJURY<br>Coronary Artery Disease |  | 18. PERIOD OF ILLNESS<br>Several Months          |  |
| 19. PLACE OF DEATH<br>Home                       |  | 20. CITY<br>Baltimore                            |  | 21. COUNTY<br>Baltimore                      |  | 22. STATE<br>Maryland                            |  | 23. ZIP CODE<br>21201                            |  | 24. SIGNATURE OF DECEASED<br>(None)              |  |
| 25. SIGNATURE OF WITNESSES<br>J. A. Wilson, M.D. |  | 26. SIGNATURE OF PHYSICIAN<br>J. A. Wilson, M.D. |  | 27. SIGNATURE OF CLERK<br>J. A. Wilson, M.D. |  | 28. SIGNATURE OF REGISTRAR<br>J. A. Wilson, M.D. |  | 29. SIGNATURE OF DECEASED<br>(None)              |  | 30. SIGNATURE OF WITNESSES<br>J. A. Wilson, M.D. |  |

## CERTIFICATE OF DEATH

Reg. Dist. No.

12087

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>  |  |   |  | c. LENGTH OF STAY IN TB  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>102 Cromer St.</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Henry</b> Middle <b>Beck</b> Last <b>Beck</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>26</b> Year <b>19 59</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Oct. 30, 1876</b>                                |  |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Wheeling, W.Va.</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>John Henry Beck</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Francis Geiger</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.  |  |   |  |
| 17. INFORMANT<br><b>Charles Beck, Westernport, Md.</b>  |  |   |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis and Myocardial Degeneration not specified as Rheumatic</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>Nov. 26, 1959</b> , to <b>Nov. 26, 1959</b> , that I last saw the deceased <b>alive on Nov. 26, 1959</b> , and that death occurred at <b>9:05 P.M.</b> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Paul R. Wilson</b>  |  |   |  | DATE SIGNED <b>11-27-59</b>  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>Ashfield St. Piedmont, W.Va.</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Nov. 29, 1959</b>                               |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. Fredrick Jr.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 1 '59</b>   |  |   |  |
| ADDRESS<br><b>Piedmont, W.Va.</b>   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12029

CERTIFICATE OF DEATH

12018

Reg. Dist. No.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   | c. LENGTH OF STAY IN 1b<br><b>4 yrs., 22 das.</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sylvan Retreat</b>   |  | d. STREET ADDRESS<br><b>1 112 4th Street</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Virginia</b> Last <b>Beehler</b>   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>25</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 24, 1879</b>  |
| 9. AGE (In years lost birthday)<br><b>80</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>William Fahnestock</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Sophia Cline</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>                                      |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs. Carrie Perdew, Flintstone, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>522 Pulmonary Hypostasis</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>422 Myocardial Regeneration</b><br>DUE TO<br>(c) <b>450 General Arteriosclerosis</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs.</b><br><b>?</b><br><b>?</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>304 Senile psychosis.</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>Nov. 3, 1955</b> to <b>Nov. 25th, 1959</b> , that I last saw the deceased alive on <b>Nov. 25th, 1959</b> , and that death occurred at <b>4:30 P.</b> M, from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE<br><b>James E. McLean</b>  |  | ADDRESS (Street, city or town, state)<br><b>49 Greene St. Cumberland</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>James E. McLean, M.D.</b>   |  | DATE SIGNED<br><b>11/26/59</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>11/28/1959</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Glendale Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Flintstone, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Knight</b>   |  | ADDRESS<br><b>Cumberland, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR<br>DATE<br><b>DEC 1 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1903

1903

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

10

NAME OF DECEASED

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

PROFESSION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

PROFESSION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

PROFESSION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12030

## CERTIFICATE OF DEATH

Reg. Dist. No.

12019

|  |                                     |  |   |
|--|-------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                     | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>22 FROSTBURG</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL</b>  |                                     | d. STREET ADDRESS<br><b>174 MT. PLEASANT STREET</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BOY</b> Middle <b>BOY</b> Last <b>BERNARD</b>  |                                     | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>30</b> Year <b>1959</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>NOVEMBER 24, 1959</b>                      |
| 9. AGE (In years lost birthday) yrs.<br><b>6</b>   |                                     | 10. IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
|  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                     |  |   |
| 13. FATHER'S NAME<br><b>WILLIAM BERNARD JR.</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>PATRICIA ANN NEWMAN</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                     | 16. SOCIAL SECURITY NO.  |   |
|  |                                     | INFORMANT<br><b>MEMORIAL HOSPITAL</b> Address<br><b>CUMBERLAND, MARYLAND</b>   |   |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>760.5 Prematurity</b><br>DUE TO (b) <b>Possible Aspiration of Vomitus</b><br>DUE TO (c) <b>Possible brain hemorrhage</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Nov 24, 1959</b> to <b>Nov 30, 1959</b> that I last saw the deceased alive on <b>Nov 30, 1959</b> , and that death occurred at <b>10:20 P.M.</b> from the causes and on the date stated above.            |                                     |  |   |
| ACTUAL SIGNATURE<br><b>A. J. Hashim</b>  |                                     | ADDRESS (Street, city or town, state)<br><b>20 Greene St Cumberland Md.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>DR. HASHIM</b>   |                                     | DATE SIGNED<br><b>M.D.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>12-3-59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Clean New York</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Clean 747</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. P. Garrett Frostburg Md</b>  |                                     | 24a. REC'D BY REGISTRAR<br><b>DEC 3 '59</b>  |   |
| ADDRESS<br><b>2060 314 X 01</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CENTRE FOR DEATH

13038

ALLICANY

WARRLAND

ALLICANY

FROSTLAND

6 DAYS

CUTTERLAND

17th ST. PLACANT CORNER

HOSPITAL BARNACK AVE.

NOVEMBER 30

SEWARD

BOY

EVERY

NOVEMBER 21, 1939

WHITE

WHITE

CUTTERLAND, WYOMING

PATRICIA ANN PERMAN

WILLIAM GERHARD JR.

MEMORIAL HOSPITAL CUTTERLAND, WYOMING

*Handwritten notes:*  
I was born at  
Cutterland, Wyoming  
on November 21, 1939  
at the Memorial Hospital.

*Handwritten notes:*  
I was born at  
Cutterland, Wyoming  
on November 21, 1939  
at the Memorial Hospital.

DR. HASTIN

*Handwritten notes:*  
I was born at  
Cutterland, Wyoming  
on November 21, 1939  
at the Memorial Hospital.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12020

Reg. Dist. No.

12031

|   |  |   |   |   |  |   |   |  |
|---|--|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>40 years</b>                  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b> |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>307 Arch St.</b>   |  |   |   | d. STREET ADDRESS<br><b>307 Arch St.</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Boggs</b> Last <b>Boggs</b>   |  |   |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>16</b> Year <b>19 59</b>   |  |   |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 11, 1886</b>   |   |  |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>73</b> Days <b>73</b>  |   | IF UNDER 24 HRS.<br>Hours <b>73</b> Min. <b>73</b>  |  |   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Laborer</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>City Cumberland</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Oldtown, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Augusta Boggs</b>   |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Milinda Kifer</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-10-2019</b>   |   | 17. INFORMANT<br><b>Mrs. Wm. Boggs, Cumberland, Md.</b>   |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br>DUE TO <b>Strangulation from hanging</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>974X</b><br>DUE TO (c)  |  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 mins</b><br><b>5 mins</b>                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Mental Depression</b>   |  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Hanged self in coal shed</b> |   |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>7:30 AM 11-16 19 59</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>            |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Cumberland, Md.</b>  |  | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |   |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.  |  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic MD</b>  |  |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |  |
|   |  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |   | 22b. DATE THEREOF<br><b>11-18-1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>                                |   |  |
|   |  |   |   |   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                           |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>  |  |   |   | ADDRESS   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 19 '59</b>   |   |  |
|   |  |   |   |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12021

12088

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>PA</b> b. COUNTY <b>SOMERSET</b> ✓                     |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FROSTBURG</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MINER'S HOSPITAL</b>   |  |   |  | d. STREET ADDRESS<br><b>106 BROADWAY</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>HENERITTA AGNES BOLDEN</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>NOV 21 1959</b>  |  |   |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>MAR 12, 1877</b>   |  |
| 9. AGE (In years last birthday)<br><b>82 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSEWIFE</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>SOMERSET CO, PA</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>FRANCIS MCKENZIE</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>LEEANNA WARNER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>011111111</b>   |  |   |  |
| 17. INFORMANT<br><b>William C. Bolden</b>   |  |   |  | Address<br><b>FROSTBURG RD 2 MD.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-vascular disease</b><br>DUE TO<br>(c) <b>10 yrs.</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility - Blind.</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>June 1, 1958</b> , to <b>11-21, 1959</b> , that I last saw the deceased alive on <b>11-21, 1959</b> , and that death occurred at <b>3:45</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>39 W. Main St. Frostburg, Md.</b><br>DATE SIGNED <b>11/21/59</b><br>ACTUAL SIGNATURE <b>H.C. Diehl</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>H.C. Diehl, M.D.</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 22b. DATE THEREOF<br><b>NOV 24, 1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>FANZEL CEMETERY</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>FROSTBURG RD 2, GARRETT CO MD</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Mark Ray Leckony</b>   |  |   |  | ADDRESS<br><b>325 MAIN ST. MEYERSDALE, PA</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 27 '59</b>                                     |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>  |  |   |  |

28951

1. The first part of the document is a letter from the author to the editor, dated 10/10/1964. The letter discusses the author's interest in the topic of the journal and mentions that the author has been thinking about the topic for some time. The author also mentions that the author has been thinking about the topic for some time.

## CERTIFICATE OF DEATH

Reg. Dist. No.

12022

12032

|   |                                  |   |   |  |   |
|---|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>7 days</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>22 Frostburg,</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Memorial Hospital</b>  |                                  |   | d. STREET ADDRESS<br><b>61 Grant Street</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jenkin</b> Middle <b>Bradley</b> Last <b>Bradley</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>4th</b> Year <b>1959</b>   |  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 7th, 1879</b>  |  | 9. AGE (In years last birthday)<br><b>80 yrs.</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret.-Hoist Operator</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>F'bg. Fuel Co.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  |   |   |  |   |
| 13. FATHER'S NAME<br><b>Edward R. Bradley</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Thomas</b>   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  |   | 16. SOCIAL SECURITY NO.<br><b>216-03-4733</b>   |  |   |
| 17. INFORMANT<br><b>Mrs. Tillie S. Bradley, Frostburg, Md.</b>  |                                  |   | Address <b>61 Grant Street</b>  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Uremia</b><br>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>generalized arteriosclerosis</b>     |                                  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)   |                                  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Manth, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Allegany Hotel</b>          |   |
| 20f. (City or town)<br><b>Frostburg,</b>  |                                  | (County)<br><b>Md.</b>  |   | (State)<br><b>Md.</b>  |   |
| 21. I certify that I attended the deceased from <b>10/25</b> , 19 <b>59</b> , to <b>11/4</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/4</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Allegany Hotel</b> DATE SIGNED <b>11/21/59</b> |                                  |   |   |  |   |
| ACTUAL SIGNATURE <b>George M. Brown</b>   |                                  | M.D. <b>Allegany Hotel</b>  |   |  |   |
| PHYSICIAN'S NAME (Type) <b>Cumberland Md</b>  |                                  |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11-7-59</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>F'bg. Memorial Park</b>   |   |
| 22d. LOCATION (City/town, or county)<br><b>Frostburg,</b>   |                                  | (State)<br><b>Md.</b>   |   |  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Durst, Frostburg, Md.</b>  |                                  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 9 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hanna</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18083

CERTIFICATE OF DEATH

18083

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

12102

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |   |   |   |   |  |
|--|----------------------------------|---|---|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Savage,</b>   |                                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Savage,</b>                                      |   |   |  |
| c. LENGTH OF STAY IN 1b<br><b>Lifetime</b>   |                                  |   |   | d. STREET ADDRESS<br><b>Glenn Savage Road</b>   |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Glenn Savage Road</b>   |                                  |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Mary Frances Brailer</b>   |                                  | First Middle Last   |   | 4. DATE OF DEATH<br><b>November 24th, 1959</b>  |   | Month Day Year  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 23rd, 1880</b> |   | 9. AGE (In years lost birthday)<br><b>79</b> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housekeeper</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own housework</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                              |  |
| 13. FATHER'S NAME<br><b>George C. Brailer</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma Durkin</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |   | INFORMANT<br><b>John H. Brailer, Mt. Savage, Md.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>420.0</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br>DUE TO <b>(b) Cerebral Hemorrhage</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>1st + 2nd degree burns of face</b> |                                  |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>12 hrs.</b>                      |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <b>11/18</b> , 19 <b>59</b> , to <b>11/24</b> , 19 <b>59</b> , that I lost s/he the deceased alive on <b>11/23/59</b> , 19 <b>59</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.   |                                  |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>Martin M. Rothstein M.D.</b>   |                                  |   |   | ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED <b>11/24/59</b>  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Martin M. Rothstein</b>   |                                  |   |   | <b>Frostburg, Md.</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-27-59</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Mt. Savage, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Durst, Frostburg, Md.</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>NOV 27 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Calvin S. Kline</b>                    |  |

DP



2013

YMC-9000

12103

## CERTIFICATE OF DEATH

Reg. Dist. No.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |  |                               |  |  |  |  |  |
|--|--|-------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |  |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>MT. SAVAGE</b>   |  |                               |  | c. LENGTH OF STAY IN 1b <b>84 DAYS</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>   |  |                               |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>DANIEL O. BRIDGES</b>   |  |                               |  | 4. DATE OF DEATH <b>NOVEMBER 8 1959</b>  |  |  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>MARCH 24, 1883</b>                                   |  |
| 9. AGE (In years last birthday) <b>76</b> yrs.   |  | IF UNDER 1 YEAR Months Days   |  | IF UNDER 24 HRS. Hours Min.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Dealer</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND Beans Cove Pa.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  |                               |  |  |  |  |  |
| 13. FATHER'S NAME <b>BENTON BRIDGES</b>  |  |                               |  | 14. MOTHER'S MAIDEN NAME <b>ANNA MILLER</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |                               |  | 16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>433.0 Unemia</b><br>DUE TO (b) <b>Chronic Myocarditis - Heart Block</b><br>DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b> |  |                               |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>  |  |                               |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |                               |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)   |  |                               |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>July</b> , 1958, to <b>Nov 8</b> , 1959, that I lost s/he the deceased alive on <b>Nov 8</b> , 1959, and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.                        |  |                               |  |  |  |  |  |
| ADDRESS (Street, city or town, state)  |  |                               |  | DATE SIGNED  |  |  |  |
| ACTUAL SIGNATURE <b>Dr. Overton Himmelwright</b> M.D. <b>133 Virginia Ave</b>  |  |                               |  | <b>11/10/59</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>DR. OVERTON HIMMELWRIGHT</b>  |  |                               |  | <b>Cumberland, Md</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 22b. DATE THEREOF             |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION (City, town, or county) (State)                            |  |
| <b>Burial</b>  |  | <b>11/11/59</b>               |  | <b>Mt. Savage Meth Cem.</b>  |  | <b>Mt. Savage, Maryland</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>   |  |                               |  | 24a. REC'D BY REGISTRAR <b>NOV 12 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>C. E. Hafer</b>                            |  |

12034

WESTLAND STATE DEPARTMENT OF HEALTH - BATHING

CERTIFICATE OF DEATH

12103

ALLICANY

MARYLAND

ALLICANY

MT. SAVAGE

84 DAYS

MT. SAVAGE

GARRICK MEMORIAL

MEMORIAL HOSPITAL

BRIDGES

CANNEL

MARCH 27, 1933

MALE WHITE

MISS MILLER

BENTON BRIDGES

MEMORIAL HOSPITAL N. CUMBERLAND, MARYLAND

*Handwritten notes and signatures, including "DR. GERTON HINCUS" and "DR. GERTON HINCUS" (mirrored).*

12025

12033

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>ALLEGANY</b>  |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b>  |  | b. COUNTY<br><b>ALLEGANY</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND,</b>   |  | c. LENGTH OF STAY IN 1b<br><b>2 DAYS</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)<br><b>MEMORIAL HOSPITAL</b>   |  | e. STREET ADDRESS<br><b>WARWICK AVES. 1</b>   |  | f. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARY</b>  |  | First<br><b>MARY</b>  |  | Middle<br><b>ELIZABETH</b>  |  | Last<br><b>BROWN</b>   |  |
| 4. DATE OF DEATH<br>Month<br><b>NOVEMBER 10,</b>   |  | Day<br><b>19</b>  |  | Year<br><b>59</b>   |  |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>AUGUST 5, 1885</b>                                    |  |
| 9. AGE (In years last birthday)<br><b>74</b>   |  | IF UNDER 1 YEAR<br>Months<br><b>74</b>  |  | IF UNDER 24 HRS.<br>Days<br><b>74</b>   |  | Hours<br><b>74</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWORK</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ownhome</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                              |  |
| 13. FATHER'S NAME<br><b>MANLEY, Patrick</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)<br><b>422.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c) |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Acute Congestive Heart Failure</b><br><b>Chronic Hypertension</b><br><b>Arteriosclerotic Cardiovascular Disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a. m.<br>p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Nov 10, 1959</b> to <b>Nov 10, 1959</b> , that I last saw the deceased alive on <b>Nov 10, 1959</b> , and that death occurred at <b>9:25 PM</b> from the causes and on the date stated above.                                     |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>DR. R. XXXXX</b>  |  | M.D. <b>133 Virginia Ave</b>  |  | ADDRESS (Street, city or town, state)<br><b>Cumberland, Md</b>  |  | DATE SIGNED<br><b>11/13/59</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>II-14-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>  |  | ADDRESS<br><b>Cumberland, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>NOV 17 1959</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. House</b>                         |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)  
15M 9/58

CLINICAL INVESTIGATION

1. NAME

12 FEB 1985 105

27:184

DR. R. C. GREGG, JR.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12026

12034

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                        |  |                                |
|--|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY Allehany MARYLAND   |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Allegany                            |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland  |                        | c. LENGTH OF STAY IN 1b 60 years   |                                |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland   |                        |  |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Bedford St.   |                        | d. STREET ADDRESS 707 Bedford St.  |                                |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                        |  |                                |
| 3. NAME OF DECEASED (Type or print) First WILLIAM Middle ARTHUR Last BRUBAKER  |                        | 4. DATE OF DEATH Nov. 6, 19 59   |                                |
| 5. SEX Male  | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 18, 1872 |
| 9. AGE (In years last birthday) 87 yrs.  |                        | IF UNDER 1 YEAR Months Days Hours Min.   |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodial  |                        | 10b. KIND OF BUSINESS OR INDUSTRY Municipal Bldg.  |                                |
| 11. BIRTHPLACE (State or foreign country) Maryland   |                        | 12. CITIZEN OF WHAT COUNTRY? USA   |                                |
| 13. FATHER'S NAME Isaac Brubaker   |                        | 14. MOTHER'S MAIDEN NAME Frances (?)   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No  |                        | 16. SOCIAL SECURITY NO. None   |                                |
| 17. INFORMANT Mrs. Austin Stine  |                        | Address Cumberland, Md.  |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.1 Coronary occlusion<br>DUE TO (b) Generalized arteriosclerosis<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH 3hr<br>yrs |                        |  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19   |                        | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                        | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that I attended the deceased from Oct 10, 1959, to Nov 6, 1959, that I last saw the deceased alive on Nov 6, 1959, and that death occurred at M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE George M. Snore M.D. Addressed to Hotel 4/21/57<br>PHYSICIAN'S NAME (Type) Cumberland Md   |                        |  |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial   |                        | 22b. DATE THEREOF Nov. 9, 1959   |                                |
| 22c. NAME OF CEMETERY OR CREMATORY Hill Crest Burial Park  |                        | 22d. LOCATION (City, town, or county) (State) Cumberland, Md.  |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight  |                        | ADDRESS Cumberland, Md.  |                                |
| 24a. REC'D BY REGISTRAR DATE NOV 12 '59  |                        | 24b. REGISTRAR'S SIGNATURE Arthur S. Kneib   |                                |

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

|  |  |   |  |  |  |                                     |  |  |  |
|--|--|---|--|--|--|-------------------------------------|--|--|--|
| 1. FULL NAME OF DECEASED<br>JAMES EARL RAY |  | 2. SEX<br>Male                            |  | 3. RACE<br>White                         |  | 4. DATE OF BIRTH<br>May 19, 1928    |  | 5. PLACE OF BIRTH<br>Jackson, Mississippi  |  |
| 6. OCCUPATION<br>Attorney                  |  | 7. MARITAL STATUS<br>Single               |  | 8. EDUCATION<br>High School              |  | 9. RELIGION<br>Methodist            |  | 10. SOCIAL SECURITY NUMBER<br>1-100-000000 |  |
| 11. DATE OF DEATH<br>April 4, 1968         |  | 12. TIME OF DEATH<br>2:01 PM              |  | 13. PLACE OF DEATH<br>Memphis, Tennessee |  | 14. CAUSE OF DEATH<br>Gunshot wound |  | 15. MANNER OF DEATH<br>Suicide             |  |
| 16. SIGNATURE OF DECEASED<br>(None)        |  | 17. SIGNATURE OF NEXT OF KIN<br>(None)    |  | 18. SIGNATURE OF PHYSICIAN<br>(None)     |  | 19. SIGNATURE OF CORONER<br>(None)  |  | 20. SIGNATURE OF REGISTRAR<br>(None)       |  |
| 21. FULL NAME OF REGISTRAR<br>John Doe     |  | 22. ADDRESS<br>123 Main St, Baltimore, MD |  | 23. CITY<br>Baltimore                    |  | 24. STATE<br>Maryland               |  | 25. ZIP CODE<br>21201                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12089

## CERTIFICATE OF DEATH

Reg. Dist. No.

12027

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> <u>MARYLAND</u>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frostburg</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Mt. Savage</u>   |  |
| c. LENGTH OF STAY IN 1b<br><u>39 days</u>  |                                  | d. STREET ADDRESS<br><u>12260 North Saginaw St.,<br/>Mr's. Mae Iser, Mt. Morris, Michigan</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Miner's Hospital</u>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Sarah</u> Middle <u>Alice</u> Last <u>Byrne</u>  |                                  | 4. DATE OF DEATH<br>Month <u>November</u> Day <u>20th</u> Year <u>1959</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Feb. 24th, 1871</u> |
| 9. AGE (In years last birthday)<br><u>88</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own housework</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Unknown</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>  </u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Intractable heart failure</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO<br>(c) <u>  </u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>15 yrs.</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>  </u>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>  </u>  |                                  | 20f. (City or town) (County) (State)<br><u>  </u>   |  |
| 21. I certify that I attended the deceased from <u>Oct. 13, 1959</u> to <u>Nov 20, 1959</u> that I last saw the deceased alive on <u>11/20</u> , 19 <u>59</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Broadway</u> DATE SIGNED <u>11/21/59</u>       |                                  |   |  |
| ACTUAL SIGNATURE <u>Alvin Walters</u> M.D.   |                                  | PHYSICIAN'S NAME (Type) <u>Alvin Walters</u> " <u>Frostburg</u> <u>Md.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 22b. DATE THEREOF<br><u>11-23-59</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>ST. GEORGE</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>MT. SAVAGE</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph R. Rust</u>  |                                  | 24a. REC'D BY REGISTRAR<br><u>NOV 25 '59</u>  |  |
| ADDRESS<br><u>Frostburg Md.</u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>  |  |

1951

2

1

1992

12035

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |   |   |                                |
|---|----------------------------------|---|--|---|---|---|--------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |   |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1 Mo 29 days</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>                                       |   |   |                                |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>648 N. Mechanic St.,</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Fayette</b> Middle <b>Earl</b> Last <b>Carder</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>11/</b> Day <b>8/</b> Year <b>1959</b>   |   |   |                                |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 17, 1890</b> |   | 9. AGE (In years lost birthday)<br><b>69</b> yrs. | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired C&amp;P Telephone Company employee</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>W. Va.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                |
| 13. FATHER'S NAME<br><b>Lafayette Carder</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Susan Sanders</b>  |   |   |                                |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>212-05-0788A</b>  |  | INFORMANT<br><b>Eugene Carder</b>   |   | Address<br><b>Oldtown, Maryland</b>   |                                |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of colon metastasizing to brain in lungs</b><br>DUE TO <b>6 months</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO <b>(c)</b> |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |   |   |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |                                |
| 21. I certify that I attended the deceased from <b>Nov. 7, 1959</b> to <b>Nov. 8, 1959</b> that I last saw the deceased alive on <b>Nov. 7, 1959</b> and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above.   |                                  |   |  |   |   |   |                                |
| ACTUAL SIGNATURE<br><b>B. M. Schneider</b>  |                                  | M.D.<br><b>43</b>   |  | ADDRESS (Street, city or town, state)<br><b>Cumberland, Md</b>  |   | DATE SIGNED<br><b>11/9/59</b>   |                                |
| PHYSICIAN'S NAME (Type)   |                                  |   |  |   |   |   |                                |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/11/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland Maryland</b>                       |                                |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ruth E. Silcox</b>   |                                  |   |  | ADDRESS<br><b>Cumberland Maryland</b>   |   | 24a. REC'D BY REGISTRAR<br><b>NOV 10 '59</b>  |                                |
|   |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Howard</b>   |   |   |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18035

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

18035

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Date of registration: \_\_\_\_\_





15086

CERTIFICATE OF DEATH

15086

ALLERANY

MARYLAND

ALLEGANY

CUMBERLAND

7 DAYS

CUMBERLAND

103 BROADWAY STREET

ROYAL L HOSPITAL

NOVEMBER 20

CIGNI

ANTHONY

20

NOV. 14, 1900

WHITE

U.S.A.

WASHINGTON, D.C.

ALLIED CO. WELFARE BOARD

CASE NUMBER

RACHEL

VALENTINE CIGNI

MARTIN & MORGAN AVENUE  
FEDERAL HOSPITAL - CUMBERLAND, MARYLAND

*[Faint, mostly illegible handwritten text follows, including what appears to be a signature and date:]*

1900

DR. GEORGE C. HARRIS

10-1-1900 - 10-1-1900 - 10-1-1900

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12033

Reg. Dist. No.

12104

Item 9 FilmG251 11-6-59 et

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Corriganville</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>62 years</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Olie</b> Middle <b>Bell</b> Last <b>Clites</b>  |                                  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>1</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 27, 1872</b> |
| 9. AGE (In years last birthday)<br><b>87</b> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cooks Mille, Pennsylvania</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>John E. Logsdon</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Lowery</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Floyd G. Clites, Corriganville, Md.</b>   |                                  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute cardiac Failure</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Arteriosclerotic Cardiovascular disease</b><br>DUE TO (c)  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  | DATE SIGNED   |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Nov. 4, 1959</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Porter Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hyndman, Pa. RD#1</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harvey A. Leiper</b>   |                                  | ADDRESS<br><b>Hyndman, Pa.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>NOV 3 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thomas</b>   |  |

1-10-38

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>JAMES J. HARRIS  |  | 2. SEX<br>Male                           |  |
| 3. AGE<br>45                            |  | 4. RACE<br>White                         |  |
| 5. DATE OF DEATH<br>1-10-38             |  | 6. PLACE OF DEATH<br>Home                |  |
| 7. OCCUPATION<br>Carpenter              |  | 8. CAUSE OF DEATH<br>Heart Disease       |  |
| 9. MANNER OF DEATH<br>Natural           |  | 10. SIGNATURE OF EXAMINER<br>[Signature] |  |
| 11. SIGNATURE OF WITNESS<br>[Signature] |  | 12. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 13. SIGNATURE OF WITNESS<br>[Signature] |  | 14. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 15. SIGNATURE OF WITNESS<br>[Signature] |  | 16. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 17. SIGNATURE OF WITNESS<br>[Signature] |  | 18. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 19. SIGNATURE OF WITNESS<br>[Signature] |  | 20. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 21. SIGNATURE OF WITNESS<br>[Signature] |  | 22. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 23. SIGNATURE OF WITNESS<br>[Signature] |  | 24. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 25. SIGNATURE OF WITNESS<br>[Signature] |  | 26. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 27. SIGNATURE OF WITNESS<br>[Signature] |  | 28. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 29. SIGNATURE OF WITNESS<br>[Signature] |  | 30. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 31. SIGNATURE OF WITNESS<br>[Signature] |  | 32. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 33. SIGNATURE OF WITNESS<br>[Signature] |  | 34. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 35. SIGNATURE OF WITNESS<br>[Signature] |  | 36. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 37. SIGNATURE OF WITNESS<br>[Signature] |  | 38. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 39. SIGNATURE OF WITNESS<br>[Signature] |  | 40. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 41. SIGNATURE OF WITNESS<br>[Signature] |  | 42. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 43. SIGNATURE OF WITNESS<br>[Signature] |  | 44. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 45. SIGNATURE OF WITNESS<br>[Signature] |  | 46. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 47. SIGNATURE OF WITNESS<br>[Signature] |  | 48. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 49. SIGNATURE OF WITNESS<br>[Signature] |  | 50. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 51. SIGNATURE OF WITNESS<br>[Signature] |  | 52. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 53. SIGNATURE OF WITNESS<br>[Signature] |  | 54. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 55. SIGNATURE OF WITNESS<br>[Signature] |  | 56. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 57. SIGNATURE OF WITNESS<br>[Signature] |  | 58. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 59. SIGNATURE OF WITNESS<br>[Signature] |  | 60. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 61. SIGNATURE OF WITNESS<br>[Signature] |  | 62. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 63. SIGNATURE OF WITNESS<br>[Signature] |  | 64. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 65. SIGNATURE OF WITNESS<br>[Signature] |  | 66. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 67. SIGNATURE OF WITNESS<br>[Signature] |  | 68. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 69. SIGNATURE OF WITNESS<br>[Signature] |  | 70. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 71. SIGNATURE OF WITNESS<br>[Signature] |  | 72. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 73. SIGNATURE OF WITNESS<br>[Signature] |  | 74. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 75. SIGNATURE OF WITNESS<br>[Signature] |  | 76. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 77. SIGNATURE OF WITNESS<br>[Signature] |  | 78. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 79. SIGNATURE OF WITNESS<br>[Signature] |  | 80. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 81. SIGNATURE OF WITNESS<br>[Signature] |  | 82. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 83. SIGNATURE OF WITNESS<br>[Signature] |  | 84. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 85. SIGNATURE OF WITNESS<br>[Signature] |  | 86. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 87. SIGNATURE OF WITNESS<br>[Signature] |  | 88. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 89. SIGNATURE OF WITNESS<br>[Signature] |  | 90. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 91. SIGNATURE OF WITNESS<br>[Signature] |  | 92. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 93. SIGNATURE OF WITNESS<br>[Signature] |  | 94. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 95. SIGNATURE OF WITNESS<br>[Signature] |  | 96. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 97. SIGNATURE OF WITNESS<br>[Signature] |  | 98. SIGNATURE OF WITNESS<br>[Signature]  |  |
| 99. SIGNATURE OF WITNESS<br>[Signature] |  | 100. SIGNATURE OF WITNESS<br>[Signature] |  |

COMMONWEALTH OF MASSACHUSETTS

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

## CERTIFICATE OF DEATH

12032

Reg. Dist. No.

12037

|  |                                  |  |                                      |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>10/15/58</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Henry</b> Last <b>Coleman</b>   |                                  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>15</b> , Year <b>1959</b>   |                                      |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/20/1872</b> |
| 9. AGE (In years last birthday) yrs. <b>87</b>   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Carpenter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Carpentering</b>   |                                      |
| 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Samuel Coleman</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Damrom</b>   |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                      |
| INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>  |                                  | <b>Allegany County Infirmary Records</b>   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Hypertension</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Hemorrhage</b> DUE TO<br>(c) <b>Cerebral Arteriosclerosis</b> |                                  |  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia</b>  |                                  |  |                                      |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs.</b>   |                                  |  |                                      |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |                                      |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>10/15/58</b> , 19__ to <b>11/15/59</b> , 19__, that I last saw the deceased alive on <b>11/14/59</b> , 19__, and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above.  |                                  |  |                                      |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>Greene Street</b> DATE SIGNED <b>11/16/59</b>   |                                      |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>   |                                  | <b>Cumberland, Maryland</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Nov. 18, 1959</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Morris Hill Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hillsboro, N. C.</b>   |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Knight</b>  |                                  | ADDRESS<br><b>Cumberland, Md.</b>  |                                      |
| 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 18 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |                                      |

1

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1903

1903

Allegany

Allegany

Allegany

Cambridge

10/15/58

Cambridge

120 Main St. Street

Allegany County Infirmary

John

John

John

November 15

87

10/20/172

White

Male

U. S. A.

North Carolina

Received - Carpenter

W. B. DUNN

Samuel Johnson

P.O. Box 599

Allegany County Infirmary Records

None

11/15/58

10/15/58

11/15/58

8:10A

11/15/58

Green Street

Cambridge, Maryland

Dr. James A. Holman

Nov. 15, 1900 North Carolina Cemetery

Green Street



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12038

## CERTIFICATE OF DEATH

Reg. Dist. No.

12031

|   |  |                               |  |  |  |   |  |
|---|--|-------------------------------|--|--|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND   |  |                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>  |  |                               |  | c. LENGTH OF STAY IN 1b <b>DOA</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>   |  |                               |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES OMER CRABTREE</b>  |  |                               |  | 4. DATE OF DEATH Month Day Year <b>November 29 19 59</b>   |  |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>1906 Sept. 30, 1959</b>                           |  |
| 9. AGE (In years lost birthday) <b>53</b> yrs.  |  | IF UNDER 1 YEAR Months Days   |  | IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>   |  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |                               |  |  |  |   |  |
| 13. FATHER'S NAME <b>Milford L. Crabtree</b>  |  |                               |  | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Printy</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |                               |  | 16. SOCIAL SECURITY NO. <b>214-05-6446</b>   |  |   |  |
| 17. INFORMANT <b>Mrs. Harriett Crabtree</b>   |  |                               |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>420.1 DUE TO <b>Coronary Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>10 yrs</b><br>DUE TO (c) |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                               |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                               |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |  |                               |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                               |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I attended the deceased from <b>November 19 53</b> to <b>November 19 59</b> that I last saw the deceased alive on <b>11/30/59</b> and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>122 S. Centre Street</b> DATE SIGNED <b>11/30/59</b><br>ACTUAL SIGNATURE <b>Richard J. Williams</b> M.D. <b>122 So. Centre St. Cumberland, Md.</b><br>PHYSICIAN'S NAME (Type) <b>R. J. Williams</b> M.D. |  |                               |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |                               |  | 22b. DATE THEREOF <b>12/2/59</b>   |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>  |  |                               |  | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>   |  |                               |  | 24a. REC'D BY REGISTRAR <b>DEC 4 '59</b>   |  |   |  |
| ADDRESS   |  |                               |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>  |  |   |  |



## CERTIFICATE OF DEATH

12030

Reg. Dist. No.

12039

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>West Virginia</b> b. COUNTY <b>Mineral</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keyser</b>   |   |
| c. LENGTH OF STAY IN 1b <b>3 Days</b>  |                                   | d. STREET ADDRESS <b>233 S. Main Street</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>  |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Maude</b> Middle <b>Wenner</b> Last <b>Dennison</b>  |                                   | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>24</b> Year <b>1959</b>   |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>8-22-72</b>                                     |
| 9. AGE (In years lost birthday) <b>87</b> yrs.   |                                   | 10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>Newburg, W. Va.</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>Henry Wenner</b>  |                                   | 14. MOTHER'S MAIDEN NAME <b>Martha Biggerstaff</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                                   | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>Mrs. Sara Avers, Keyser, W. Va.</b>   |                                   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b><br>DUE TO (c) <b>Disease</b> |                                   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anemia</b>  |                                   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>11/21</b> , 19 <b>59</b> , to <b>11/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/24</b> , 19 <b>59</b> , and that death occurred at <b>7:45 P.M.</b> , from the causes and on the date stated above.   |                                   |  |   |
| ACTUAL SIGNATURE <b>Leo N. Lay, Jr.</b> M.D.   |                                   | ADDRESS (Street, city or town, state) <b>452 N. Center St.</b> DATE SIGNED <b>11/25/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. L. H. Lay</b>   |                                   | <b>Cumberland Ind</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 22b. DATE THEREOF <b>11-27-59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>Queen's Point Cem.</b>   | 22d. LOCATION (City, town, or county) (State) <b>Keyser, W. Va.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas R. Smith Jr.</b>  |                                   | 24. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>   |   |
| ADDRESS <b>Keyser, W. Va.</b>  |                                   | DATE <b>NOV 27 59</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1903

1903

1903

Blank certificate form with faint lines and text for recording death information.

12040

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |   | c. LENGTH OF STAY IN 1b<br><b>9/8/59</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>DeVries</b> Last <b>DeVries</b>   |   | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>4</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/12/1883</b>   |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.   |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <b>4</b> Days <b>19</b> Hours <b>59</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Salesman</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Imperial Ice Cream Company</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Parkersburg, W. Va.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>William Thomas DeVries</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Anna Mary Humbird</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b><br><b>Allegany County Infirmary Records</b>                       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b><br>DUE TO (b) <b>Chronic Myocarditis</b><br>DUE TO (c) <b>Cerebral Arteriosclerosis</b>   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hrs</b><br><b>?</b><br><b>?</b>                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>Serious Mental Depression</b>   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>9/8/59</b> , 19____, to <b>11/4/59</b> , 19____, that I last saw the deceased alive on <b>11/3/59</b> , 19____, and that death occurred at <b>7:28 A.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b> DATE SIGNED <b>11/4/59</b> |   |  |  |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.  |   | PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>11/6/59</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 12 '59</b>  |  |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |  |

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18034

CERTIFICATE OF DEATH

12040

Allegheny

Allegheny

Allegheny

Allegheny - Cumberland

Cumberland

Allegheny County Infirmary

William Deville November 11 1899

Male White X 2/12/1883 75

Resided - Baltimore - Green Company, Baltimore, Md. U. S. A.

William Thomas Deville  
P.O. Box 259  
Allegheny County Infirmary, Allegheny, Pa.  
Cumberland, Md.

12/12/99 7:50

12/12/99

12/12/99

12/12/99

14 Greene St.  
Cumberland, Md.

Dr. James T. Nelson

John E. Baker, Cumberland, Maryland



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12041  
CERTIFICATE OF DEATH

12035

Reg. Dist. No.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>24 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anthony</b> Middle <b>J</b> Last <b>Dressman</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>17</b> Year <b>1959</b>   |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>                       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9/28/89</b>            |  |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>17</b> |  | 11. IF UNDER 24 HRS.<br>Hours <b>17</b> Min.   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>grocer</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>self</b>   |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Jospeh Dressman</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Determan</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>Chart</b>  |  |   |  |
| 17. INFORMANT<br><b>Chart</b>  |  |  |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>hepatic coma</b><br><b>584X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>cholecystitis, cholangitis</b> DUE TO<br>(c) <b>cholelithiasis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>rhumatoid arthritis (rheumatoid)</b><br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |  |  |  |  |   |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  |  |   |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |   |  |
| 21. I certify that I attended the deceased from <b>11/15</b> to <b>11/17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/17</b> , 19 <b>59</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Elizabeth Brings</b> M.D.<br>ACTUAL SIGNATURE<br>PHYSICIAN'S NAME (Type) <b>Dr. E. Brings</b> <b>55 Green Street</b>   |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  |  |   |  |
| 22b. DATE THEREOF<br><b>11/24/59</b>   |  |  |  |  |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter &amp; Paul Cem.</b>   |  |  |  |  |  |   |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland Md</b>  |  |  |  |  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Louis Stein Inc</b>   |  |  |  |  |  |   |  |
| ADDRESS<br><b>Cumb. Md.</b>  |  |  |  |  |  |   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 20 '59</b>  |  |  |  |  |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>   |  |  |  |  |  |   |  |

062

I

0

1

EP

13032

CERTIFICATE OF DEATH

13041

Deceased

Married

Allegedly

In Valid

Heart Disease

Insufficient

Unstable

13040

White

Male

Resident

Heart Disease

Heart Disease

Heart Disease

Heart Disease

Heart Disease

12042

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |   |  |   |   |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>1/27/59</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b>                                    |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>  |                                  |   |  | d. STREET ADDRESS<br><b>1 515 Fayette Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle Last <b>Dreyer</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>6,</b> Year <b>19 59</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH<br><b>6/6/1877</b>   |  | 9. AGE (In years last birthday)<br><b>82</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Lonaconing, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>James Reynolds</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Conley</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.   |  | INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b><br><b>Allegany County Infirmary Records</b>                                     |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Pulmonary congestion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO <b>?</b><br>(c) <b>Chronic myocardial degeneration</b> DUE TO <b>?</b> |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility &amp; mental depression</b>   |                                  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>1/27/59</b> , 19____, to <b>11/6/59</b> , 19____, that I last saw the deceased alive on <b>11/5/59</b> , 19____, and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>11/6/59</b>                                      |                                  |   |  |   |  |   |   |
| ACTUAL SIGNATURE<br><b>James E. McLean</b>  |                                  | PHYSICIAN'S NAME (Type)<br><b>Dr. James E. McLean</b> <b>Cumberland, Md.</b>  |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/9/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Lutheran Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland Maryland</b>                       |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Ruth E. Silcox</b> <b>Cumberland Maryland</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 10 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kane</b>   |   |

12035

CERTIFICATE OF DEATH

12042

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING

Allegany

Bartholomew

Allegany

Chapman

1/27/59

Chapman

515 Rayette Street

Allegany County Jail

Deputy

Marshall

November 5, 1959

6/2/1957

White

Female

82

Donnell, Maryland U. S. A.

Donnell

James Reynolds

North County

P.O. Box 599

Chapman, Md.

Allegany County Jail

1/27/59

1/27/59

1/27/59

1/27/59

Dr. James E. Nolan

Chapman, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12037

12043

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |   |  |   |   |   |  |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>Life</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 Cumberland</u>                                    |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Sacred Heart Hospital</u>  |                                  |   |  | d. STREET ADDRESS<br><u>1305 Bedford St.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>HELEN</u> Middle <u>DWYER</u> Last <u>DWYER</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>7</u> Year <u>19 59</u>  |   |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Mar. 13, 1886</u> |   | 9. AGE (In years last birthday)<br><u>73</u> yrs. | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Samuel Metz</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Jeanette Poole</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br>Address <u>Mrs. Wyley Franks Flint, Mich.</u>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u><br>DUE TO (c) <u>  </u>   |                                  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><br><u>?</u>                                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |                                  |   |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <u>  </u> o. m. <u>  </u> p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |   |   |   |  |
| ACTUAL SIGNATURE <u>Benedict Skitarelis</u> M.D.  |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |
| EXAMINER'S NAME (Type) <u>Benedic Skitarelis, M.D.</u>  |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |  |
|   |                                  |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>Nov. 10, 1959</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill Cemetery</u>   |   | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland, Md.</u>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Byron Kight</u> ADDRESS <u>Cumberland, Md.</u>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 12 '59</u>   |   | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kraus</u>  |  |





## CERTIFICATE OF DEATH

Reg. Dist. No.

12044

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Charles P. Price Eversole</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>11 10 19 59</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 8, 1889</b> |
| 9. AGE (In years lost birthday)<br><b>70</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Pipe Fitter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Silk</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Rockford, W. Va.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Alexander Eversole</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jane Compton</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |   |
| 17. ADDRESS<br><b>Cumberland, Md.</b>  |                                  | 18. ADDRESS<br><b>Mrs. Gay M. Eversole 567 Patterson Ave.,</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>490X</b> DUE TO <b>marked defect of lungs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lobar Pneumonia with Pleurisy</b> DUE TO <b>5 days</b><br>(c) <b>10 minutes</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>11-10-19 59</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>11-10-19 59</b> to <b>11-10-19 59</b> and that death occurred at <b>11-10-19 59</b> AM, from the causes and on the date stated above.   |                                  | 22. ADDRESS (Specify city or town, state)<br><b>16 Green Street</b>   |   |
| ACTUAL SIGNATURE<br><b>Dr. J. T. Johnson, Jr.</b>  |                                  | DATE SIGNED<br><b>11-13-59</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. J. T. Johnson, Jr.</b>   |                                  | 23. NAME OF CEMETERY OR CREMATORY<br><b>Fort Ashby Cem.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>Nov. 13, 1959</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George - Cumberland, Md.</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Nov 18 '59</b>  |   |
| ADDRESS<br><b>Cumberland, Md.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hines</b>  |   |

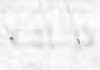
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12039

Reg. Dist. No.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Allegany</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u><br>c. LENGTH OF STAY IN 1b <u>1 Day</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital - Memorial Avenue</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u><br>d. STREET ADDRESS <u>320 Williams Street</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Harvey</u> Middle <u>Flake</u> Last <u>Flake</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>November</u> Day <u>24</u> Year <u>19 59</u>   |  | <b>5. SEX</b> <u>Male</u><br><b>6. COLOR OR RACE</b> <u>White</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |
| <b>8. DATE OF BIRTH</b> <u>August 8, 1880</u><br><b>9. AGE</b> (In years last birthday) <u>79</u> yrs.<br>IF UNDER 1 YEAR: Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>   |  | <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |   |  |  |  |
| <b>13. FATHER'S NAME</b> <u>John Thomas Flake</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Martha North</u>  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br>(If yes, give war or dates of service)<br><b>16. SOCIAL SECURITY NO.</b> <u>Wilbur E. Flake</u><br><b>17. INFORMANT</b> <u>Cumberland</u> Address <u>Maryland</u> |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u><br>DUE TO <u>443X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> |  |  |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |  | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____<br><b>20f. (City or town)</b> _____ (County) _____ (State) _____  |  |  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>   |  |  |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <u>Benedict Skitarelic</u><br><b>EXAMINER'S NAME (Type)</b> <u>Benedict Skitarelic, M.D.</u>  |  | <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>Nov. 24, 1959</u>   |  | <b>DATE SIGNED</b>  |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>  |  | <b>22b. DATE THEREOF</b> <u>11/27/59</u>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Pleasant Grove Cemetery</u>  |  |  |  |
| <b>22d. LOCATION (City, town, or county)</b> <u>Cumberland</u> (State) <u>Maryland</u> (Rural) <u>(Rural)</u>   |  | <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ruth E. Silcox</u> <u>Cumberland</u> <u>Maryland</u>  |  |   |  |  |  |
| <b>24a. REC'D BY REGISTRAR</b> <u>NOV 27 '59</u>  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Howard</u>  |  |   |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

15039

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY    |  | 2. SEX<br>Male                          |  | 3. AGE<br>35  |  | 4. RACE<br>White                        |  |
| 5. DATE OF DEATH<br>April 4, 1968        |  | 6. TIME OF DEATH<br>2:01 PM             |  | 7. PLACE OF DEATH<br>Room 308, Federal Bureau of Investigation Building, Washington, D.C. |  | 8. CITY<br>Washington, D.C.             |  |
| 9. COUNTY<br>District of Columbia        |  | 10. STATE<br>District of Columbia       |  | 11. ZIP CODE<br>20535   |  | 12. MANNER OF DEATH<br>Homicide         |  |
| 13. CAUSE OF DEATH<br>FIRE               |  | 14. MECHANISM OF DEATH<br>Gunshot wound |  | 15. INFLUENCING FACTORS<br>None   |  | 16. TOXICOLOGY<br>None                  |  |
| 17. SIGNATURE OF EXAMINER<br>[Signature] |  | 18. TITLE<br>Medical Examiner           |  | 19. SIGNATURE OF ASSISTANT<br>[Signature]   |  | 20. TITLE<br>Assistant Medical Examiner |  |
| 21. SIGNATURE OF CORONER<br>[Signature]  |  | 22. TITLE<br>Coroner                    |  | 23. SIGNATURE OF JURY<br>[Signature]  |  | 24. TITLE<br>Jury                       |  |
| 25. SIGNATURE OF WITNESS<br>[Signature]  |  | 26. TITLE<br>Witness                    |  | 27. SIGNATURE OF WITNESS<br>[Signature]   |  | 28. TITLE<br>Witness                    |  |
| 29. SIGNATURE OF WITNESS<br>[Signature]  |  | 30. TITLE<br>Witness                    |  | 31. SIGNATURE OF WITNESS<br>[Signature]   |  | 32. TITLE<br>Witness                    |  |
| 33. SIGNATURE OF WITNESS<br>[Signature]  |  | 34. TITLE<br>Witness                    |  | 35. SIGNATURE OF WITNESS<br>[Signature]   |  | 36. TITLE<br>Witness                    |  |
| 37. SIGNATURE OF WITNESS<br>[Signature]  |  | 38. TITLE<br>Witness                    |  | 39. SIGNATURE OF WITNESS<br>[Signature]   |  | 40. TITLE<br>Witness                    |  |
| 41. SIGNATURE OF WITNESS<br>[Signature]  |  | 42. TITLE<br>Witness                    |  | 43. SIGNATURE OF WITNESS<br>[Signature]   |  | 44. TITLE<br>Witness                    |  |
| 45. SIGNATURE OF WITNESS<br>[Signature]  |  | 46. TITLE<br>Witness                    |  | 47. SIGNATURE OF WITNESS<br>[Signature]   |  | 48. TITLE<br>Witness                    |  |
| 49. SIGNATURE OF WITNESS<br>[Signature]  |  | 50. TITLE<br>Witness                    |  | 51. SIGNATURE OF WITNESS<br>[Signature]   |  | 52. TITLE<br>Witness                    |  |
| 53. SIGNATURE OF WITNESS<br>[Signature]  |  | 54. TITLE<br>Witness                    |  | 55. SIGNATURE OF WITNESS<br>[Signature]   |  | 56. TITLE<br>Witness                    |  |
| 57. SIGNATURE OF WITNESS<br>[Signature]  |  | 58. TITLE<br>Witness                    |  | 59. SIGNATURE OF WITNESS<br>[Signature]   |  | 60. TITLE<br>Witness                    |  |
| 61. SIGNATURE OF WITNESS<br>[Signature]  |  | 62. TITLE<br>Witness                    |  | 63. SIGNATURE OF WITNESS<br>[Signature]   |  | 64. TITLE<br>Witness                    |  |
| 65. SIGNATURE OF WITNESS<br>[Signature]  |  | 66. TITLE<br>Witness                    |  | 67. SIGNATURE OF WITNESS<br>[Signature]   |  | 68. TITLE<br>Witness                    |  |
| 69. SIGNATURE OF WITNESS<br>[Signature]  |  | 70. TITLE<br>Witness                    |  | 71. SIGNATURE OF WITNESS<br>[Signature]   |  | 72. TITLE<br>Witness                    |  |
| 73. SIGNATURE OF WITNESS<br>[Signature]  |  | 74. TITLE<br>Witness                    |  | 75. SIGNATURE OF WITNESS<br>[Signature]   |  | 76. TITLE<br>Witness                    |  |
| 77. SIGNATURE OF WITNESS<br>[Signature]  |  | 78. TITLE<br>Witness                    |  | 79. SIGNATURE OF WITNESS<br>[Signature]   |  | 80. TITLE<br>Witness                    |  |
| 81. SIGNATURE OF WITNESS<br>[Signature]  |  | 82. TITLE<br>Witness                    |  | 83. SIGNATURE OF WITNESS<br>[Signature]   |  | 84. TITLE<br>Witness                    |  |
| 85. SIGNATURE OF WITNESS<br>[Signature]  |  | 86. TITLE<br>Witness                    |  | 87. SIGNATURE OF WITNESS<br>[Signature]   |  | 88. TITLE<br>Witness                    |  |
| 89. SIGNATURE OF WITNESS<br>[Signature]  |  | 90. TITLE<br>Witness                    |  | 91. SIGNATURE OF WITNESS<br>[Signature]   |  | 92. TITLE<br>Witness                    |  |
| 93. SIGNATURE OF WITNESS<br>[Signature]  |  | 94. TITLE<br>Witness                    |  | 95. SIGNATURE OF WITNESS<br>[Signature]   |  | 96. TITLE<br>Witness                    |  |
| 97. SIGNATURE OF WITNESS<br>[Signature]  |  | 98. TITLE<br>Witness                    |  | 99. SIGNATURE OF WITNESS<br>[Signature]   |  | 100. TITLE<br>Witness                   |  |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12040

Reg. Dist. No.

|  |  |   |  |   |  |   |   |  |
|--|--|---|--|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland,</b>   |  |   | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Rt. # 5 Cumberland,</b> |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>D.O.A. Memorial Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>Brant Rd. Cresaptown</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Douglas</b> Middle <b>Eugene</b> Last <b>Flanagan</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>6,</b> Year <b>19 59</b>   |  |   |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 16, 1959</b>   |   |  |
| 9. AGE (In years last birthday)<br><b>0</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>21</b>   |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>  |  |   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>Frederick Flanagan</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Riley</b>   |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Mr. Frederick Flanagan</b> Address <b>Rt. # 5 Cumberland Md.</b>  |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br><b>500x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Aspiration of Stomach Contents</b><br>(c) <b>(Also refer to Part II)</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Status Thymolympathicus; Tracheobronchitis, Mild</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b></b> o. m. <b></b> p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .   |  |   |  |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |  |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Nov. 6, 1959</b>   |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>11/8/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Danville Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Danville, Md. Allegany Co.</b>                |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 9 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Hays</b>   |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2060274XU5







may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12041

12090

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frostburg,</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>36 Hours</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Miner's Hospital</u>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Edward</u> Middle <u>Folk</u> Last <u>Folk</u>  |                                  | 4. DATE OF DEATH<br>Month <u>November</u> Day <u>24th</u> Year <u>19 59</u>  |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 14th, 1876</u>   |
| 9. AGE (In years lost birthday)<br><u>83</u> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  | 11. IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Queen City Glass</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Maryland</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>USA</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  |
| 13. FATHER'S NAME<br><u>Jonas Folk</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Susan Schultz</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>  </u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>220-07-6950</u>  |  |
| 17. INFORMANT<br><u>Mrs. Lulu B. Folk, Frostburg, Md.</u>   |                                  | Address <u>76 Mechanic St.,</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u><br>572.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Peritonitis</u> DUE TO<br>(c) <u>Diverticulitis, desc. colon, acute, with perforation</u><br>INTERVAL BETWEEN ONSET AND DEATH<br><u>Stat</u><br><u>2 d</u><br><u>2 d</u> |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)<br><u>Hypertensive C-V disease</u><br><u>(3) Unipolar L. forearm - cereb. thrombus 10/3/58</u><br><u>Generalized arteriosclerosis advanced.</u>   |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>  </u> p. m. <u>  </u><br><u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>7/22</u> , 19 <u>55</u> , to <u>11/24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11/24</u> , 19 <u>59</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>26 W. Mechanic St.,</u> DATE SIGNED <u>  </u>   |                                  |  |  |
| ACTUAL SIGNATURE <u>Frank T. Harrat</u> M.D.  |                                  | PHYSICIAN'S NAME (Type) <u>Frank T. Harrat</u> <u>  </u> <u>Frostburg,</u> <u>Md.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>11-27-59</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>F'bg. Memorial Park</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Frostburg,</u> <u>Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph R. Durst, Frostburg, Md.</u>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 27 '59</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>  </u>   |                                  |  |  |

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2c, Film G252 11/20/59 iwk

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

12047

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

9 hrs. 50 min.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

Lonaconing

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☒3. NAME OF  
DECEASED  
(Type or print)First  
FrankMiddle  
AaronLast  
Grindle4. DATE  
OF  
DEATH

Month

Day

Year

11/8/59

19

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10/14/1881

9. AGE (In years  
and days)78  
yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Baker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Aaron Grindle

14. MOTHER'S MAIDEN NAME

Janet Connor

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Miss Esther Molzshue, Lonaconing, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Lobar Pneumonia, bilateral

INTERVAL BETWEEN  
ONSET AND DEATH

3 days

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

Pneumococcus

3 days

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Chronic Myocarditis; anemia; arthritis, marked.

19. WAS AUTOPSY  
PERFORMED?  
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS  
PRIMARY ☐ or CONTRIBUTING ☐  
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour  
a. m.  
p. m.

19

20d. INJURY OCCURRED

While  
at work ☐Not while  
at work ☐20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐ACTUAL  
SIGNATURE

Benedict Skitarelic

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S  
NAME (Type)

Benedict Skitarelic, M.D.

DEPUTY MEDICAL EXAMINER ☒

Nov. 8, 1959

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

11/9/1959

22c. NAME OF CEMETERY OR CREMATORY

Oak Hill Cemetery

22d. LOCATION (City, town, or county)

Lonaconing, MD.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

GEORGE EICHORN

ADDRESS

LONA CONING, MD.

24a. REC'D BY REGISTRAR

DATE NOV 10 '59

24b. REGISTRAR'S SIGNATURE

Arthur J. Kraus



## CERTIFICATE OF DEATH

Reg. Dist. No.

12043

12048

|  |                               |  |                                    |   |  |   |  |
|--|-------------------------------|--|------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>   |                               |  |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>   |                               |  |                                    | c. LENGTH OF STAY IN 1b <u>15 HOURS</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART</u>   |                               |  |                                    | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>FREDERICK William GROWDEN</u>   |                               |  |                                    | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>4</u> Year <u>19 59</u>  |  |   |  |
| 5. SEX <u>MALE</u>   | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-31-1872</u> |   | 9. AGE (In years last birthday) <u>86</u> yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min.                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired carpenter</u>   |                               |  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY <u>Vandegrift Construction Co.</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Cumberland Valley, Pa.</u>   |  |
| 13. FATHER'S NAME <u>JOSEPH GROWDEN (D)</u>  |                               |  |                                    | 14. MOTHER'S MAIDEN NAME <u>SARAH J. Wentling</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               |  |                                    | 16. SOCIAL SECURITY NO. <u>217-10-1067</u>  |  |   |  |
| 17. INFORMANT <u>Mr. Edgar D. Growden</u>  |                               |  |                                    | Address <u>818 Gephart Drive</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure and Dehydration</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease, with cardiomegaly</u><br>and old myocardial infarctions. (c) <u>and old myocardial infarctions.</u> |                               |  |                                    |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Irritative Oropharyngitis</u>   |                               |  |                                    |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               |  |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
|  |                               |  |                                    | 20f. (City or town)   |  | (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>November 3, 1959</u> to <u>November 4, 1959</u> that I last saw the deceased alive on <u>November 3, 1959</u> and that death occurred at <u>8:05 a.m.</u> from the causes and on the date stated above.   |                               |  |                                    |   |  |   |  |
| ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u>  |                               |  |                                    | ADDRESS (Street, city or town, state) <u>Algonquin Hotel, 11/4/59</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>   |                               |  |                                    | DATE SIGNED <u>Cumberland, Maryland.</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>11/6/59</u>   |                                    | 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>  |                               |  |                                    | ADDRESS <u>Cumberland, Md.</u>  |  | 24a. REC'D BY REGISTRAR <u>NOV 9 '59</u>                                  |  |
|  |                               |  |                                    |   |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>                         |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904

NAME OF DECEASED

AGE

DATE OF DEATH

TIME

PLACE OF DEATH

CITY

CAUSE OF DEATH

DIAGNOSIS

DATE OF BIRTH

PLACE OF BIRTH

NAME OF PHYSICIAN

SIGNATURE

NAME OF REGISTRAR

SIGNATURE

NAME OF WITNESS

SIGNATURE

NAME OF WITNESS

SIGNATURE

NAME OF WITNESS

SIGNATURE

NAME OF WITNESS

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NAME OF WITNESS

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NAME OF WITNESS

SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12044

12049

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |  |  | c. LENGTH OF STAY IN 1b<br><b>7 DAYS</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OLDTOWN</b> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |  |  |  | d. STREET ADDRESS<br><b>1</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>F.</b> Last <b>HAUGH</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>11</b> Year <b>19 59</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Unknown</b>  |  |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <b>02</b> Days <b>00</b> Hours <b>00</b> Min.  |  | 11. IF UNDER 24 HRS.<br>Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Laborer R.R.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME<br><b>CHARLES W. HAUGH</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>BERTHA PIPER</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  |   |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>  |  |  |  | Address  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF PANCREAS</b><br>157x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis to brain</b><br>DUE TO<br>(c) <b>Unknown</b>           |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of face</b>  |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>1 Nov. 19 59</b> to <b>11 Nov. 19 59</b> that I last saw the deceased alive on <b>10 Nov. 19 59</b> , and that death occurred at <b>5:37 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>598 Green St Cumberland, Md.</b> DATE SIGNED <b>11/13/59</b> |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Dr. Weisman</b> M.D.  |  |  |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>  |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Nov. 13, 1959</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Oldtown cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Oldtown, Md.</b>                              |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Knight</b>   |  |  |  | ADDRESS<br><b>Cumberland, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>NOV 16 '59</b>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur &amp; Thoma</b>   |  |  |  |  |  |   |  |

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AP

12043

CERTIFICATE OF DEATH

12043

ALLEGANY

MARYLAND

ALLEGANY

CLUTCH

7 DAYS

CLUTCH

MEMORIAL HOSPITAL

11

HOWARD

F. LAUGH

CHARLES

WHITE

MALE

B.C.

MARYLAND

DEPARTMENT OF HEALTH

REGISTERED

BIRTH RECORD

CHARLES H. HADSH

MEMORIAL HOSPITAL - WESTMINSTER, MARYLAND

12043

11

12043

DR. VERNON

12043

12043

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12105

## CERTIFICATE OF DEATH

Reg. Dist. No.

12045

|   |                                      |   |  |
|---|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lonaconing</b>   |                                      | c. LENGTH OF STAY IN 1b<br><b>X</b> <b>Lonaconing</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Douglas Avenue</b>   |                                      | e. STREET ADDRESS<br><b>Douglas Avenue</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Blanche</b> First <b>Henry</b> Last   |                                      | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>14</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>December 28, 1888</b>                             |
| 9. AGE (In years last birthday)<br><b>70</b> yrs.   |                                      | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Work</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Lonaconing, Maryland</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                      | 13. FATHER'S NAME<br><b>Robert Clark</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Anna Mae Harden</b>  |                                      | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                      | 17. INFORMANT<br><b>William Henry</b> Address <b>Lonaconing, Md.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br>260x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO (c) <b>Diabetes Mellitus</b>                    |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>years</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>   |                                      |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July</b> , 19 <b>57</b> , to <b>Nov. 14</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Oct</b> , 19 <b>59</b> , and that death occurred at <b>1 P.</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>LONA CONING MD.</b><br>DATE SIGNED <b>11.15.59</b> |                                      |   |  |
| ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.  |                                      |   |  |
| PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR.</b>  |                                      | <b>LONA CONING MD.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>11/16/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Eichhorn</b>  |                                      | ADDRESS<br><b>Lonaconing, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>NOV 18 1959</b>   |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur J. Hearn</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

1992

640750

9028

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12046

12091

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> <u>MARYLAND</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Frostburg</u>   |  | c. LENGTH OF STAY IN 1b<br><u>1 Week</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Miner 's Hospital</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lula</u> Middle <u>M.</u> Last <u>Henry</u>  |  | 4. DATE OF DEATH<br>Month <u>November</u> Day <u>21st</u> , Year <u>19 59</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 8th, 1887</u>                            |
| 9. AGE (In years last birthday)<br><u>72</u> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own housework</u>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>William E. Phillips</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Nora Ross</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>  </u>   |  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |   |
| 17. INFORMANT<br><u>Raymond E. Henry, Rt. 1, Frostburg, Md.</u>  |  | Address<br><u>  </u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u><br><u>904.6</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture Upper End Rt Humerus</u><br>DUE TO (c) <u>Sudden</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 Days</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Hypertrophy - Rheumatic Valvulitis</u>  |  |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>  </u>  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>Fell in store &amp; injured shoulder</u>                  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <u>4:00</u><br>p. m. <u>Nov 14 59</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>store</u>  | 20f. (City or town) (County) (State)<br><u>Frostburg Allegany Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><u>W O McLane</u>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><u>W O McLane</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>11-24-59</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Loar Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Rt. 1, Frostburg, Md.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Joseph R. Durst, Frostburg, Md.</u>   |  | 24a. REC'D BY REGISTRAR<br>DATE <u>NOV 25 '59</u>   |   |
|  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur L. Huns</u>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1901

NAME OF DECEASED: John J. Thompson

AGE: 45 YEARS

SEX: Male

RACE: White

DATE OF DEATH: Jan 10 1901

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

DETAILS OF DEATH: Heart Disease

SIGNATURE OF EXAMINER: W. O. McLaughlin

DATE: Jan 10 1901

WITNESSES: W. O. McLaughlin

DATE: Jan 10 1901







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12048

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland,</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>02 Cumberland,</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>200 Decatur St.,</b>   |                                  | d. STREET ADDRESS<br><b>200 Decatur St.,</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Bessie</b> Middle Last <b>Howsare</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>21,</b> Year <b>19 59</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 17, 1898</b> |
| 9. AGE (In years last birthday) yrs. <b>61</b>  |                                  | IF UNDER 1 YEAR Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Bedford Co. Penna.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Mark Howsare</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah E. Bennett</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No,</b>   |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT<br><b>Mrs. Wm. Kelty Washington, D. C.</b>  |                                  | Address <b>1332 Adams St., N.E.</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Cold and Interstitial Nephritis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 Year</b>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>11-15-59</b> to <b>11-21-59</b> , that I last saw the deceased alive on <b>11-15-59</b> , and that death occurred at <b>7:40 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>16 Greene St.,</b> DATE SIGNED <b>11/23/59</b><br>ACTUAL SIGNATURE <b>James T. Johnson M.D.</b><br>PHYSICIAN'S NAME (Type) <b>James T. Johnson M.D.</b> <b>Cumberland, Md.</b>                     |                                  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/24/59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Hope Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Nr. Artemas, Penna.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>  |                                  | ADDRESS<br><b>Cumberland, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>NOV 25 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |  |

15818

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING 19

CERTIFICATE OF DEATH

1900

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

11/11

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |                               | c. LENGTH OF STAY IN 1b <b>3 HRS.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>HELEN V. JONES</b>  |                               | 4. DATE OF DEATH <b>NOVEMBER 23 1959</b>   |   |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>JANUARY 7, 1911</b> |
| 9. AGE (In years last birthday) <b>48</b>  |                               | 10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>JOHN TWIGG</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>MINNIE HILL</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>214-05-7111</b>   |   |
| 17. INFORMANT <b>Mrs. Evelyn L. Bennett</b>  |                               | Address <b>29 Fifth St</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>158x Retro-peritoneal Sarcoma</b><br>DUE TO (b) <b>with liver metastases and ascites</b><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                               | INTERVAL BETWEEN ONSET AND DEATH <b>Approx 1 yr. 3 months</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>                          |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>July 1959</b> to <b>Nov. 23 1959</b> , that I last saw the deceased alive on <b>Nov 23 1959</b> , and that death occurred at <b>1:15 PM</b> from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <b>W M Fawcett</b>  |                               | ADDRESS (Street, city or town, state) <b>Cumberland Md</b>   |   |
| PHYSICIAN'S NAME (Type) <b>WYLIE M. FAW</b>  |                               | DATE SIGNED <b>Nov 24 1959</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>11-27-59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>   |                               | ADDRESS <b>Cumberland, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR <b>NOV 30 59</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Charles L. Howard</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH

1901

ALLEGANY

MARYLAND

ALLEGANY

CLEVELAND

CLEVELAND

25 FIFTH STREET

CENTRAL & WESTERN HOSPITAL

NOVEMBER 23 1901

JOHN

JOHN

JANUARY 7, 1901

WHITE

WHITE

CLEVELAND, OH.

CLEVELAND, OH.

HIMMIE HILL

JOHN THING

JOHN THING

JOHN THING

1901

1901

JOHN THING

JOHN THING

WYLLIE HILL



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12050

12052

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>   |                               | c. LENGTH OF STAY IN 1b <b>6/10/59</b> <b>43</b> <b>Westernport</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Kidwell</b> Last <b>Kidwell</b>  |                               | 4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 59</b>   |   |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6/14/1881</b>   |
| 9. AGE (In years last birthday) <b>78</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.   | 11. IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Cross, West Virginia</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |   |
| 13. FATHER'S NAME <b>James Tasker</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Sarah Biser</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>   |                               | 16. SOCIAL SECURITY NO. <b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b>  |   |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Pulmonary Hypostasis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Cerebral Hemorrhage</b><br>(c) <b>Cerebral Arteriosclerosis</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b><br><b>?</b><br><b>?</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Right Hemiplegia</b>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>6/10/59</b> , 19____, to <b>11/24/59</b> , 19____, that I last saw the deceased alive on <b>11/24/59</b> , 19____, and that death occurred at <b>2:25 AM</b> , from the causes and on the date stated above.  |                               |  |   |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.   |                               | ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>11/25/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>   |                               | <b>Cumberland, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>11/27/59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Phylon</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Westernport, Md</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>E. B. B. Westernport, Md</b>   |                               | ADDRESS <b>Westernport, Md</b>   |   |
| 24a. REC'D BY REGISTRAR <b>DATE NOV 30 '59</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>  |   |

CERTIFICATE OF DEATH

2082

Allegany

West Virginia

Allegany

Guernsey

6/10/59

West Virginia

101 Oakview Drive

Allegany County, West Virginia

November 25, 1959

Edwards

Leslie

73

6/11/1951

Female White

Travis, West Virginia

Monmouth

Barth Elder

James T. Elder

Guernsey, W.V.

Box 509

Allegany County, West Virginia

11/25/59

6/10/59

11/20/59

2:25 PM

11, 25/59

43 Greene St.

Guernsey, W.V.

James E. Elder

Guernsey, W.V.

Guernsey, W.V.

12093

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miner's Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Phoebe</b> Middle <b>Ellen</b> Last <b>Knepp</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>12th</b> Year <b>1959</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 17th, 1902</b>                          |  |
| 9. AGE (In years last birthday)<br><b>56</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sew. Machine Operator</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Shirt Factory</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>Emanuel Coleman</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah M. Hess</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-01-6051</b>   |  |   |  |
| 17. INFORMANT<br><b>Geo. H. Knepp</b>  |  |   |  | Address<br><b>50 1/2 Ormond St., F'burg, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO <b>Coronary Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO <b>Hypertension</b><br>(c) <b>Myocardial infarction</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m.  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>7/20</b> , 19 <b>58</b> , to <b>11/12</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>November</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Algonquin Hotel, 11/12/59</b><br>DATE SIGNED<br>ACTUAL SIGNATURE <b>George M. Simons</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>George M. Simons,</b> " <b>Cumberland, Md.</b>  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>11-15-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Lawn Mem. Gardens</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>LaVale, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joseph R. Durst,</b>  |  |   |  | ADDRESS<br><b>Frostburg, Md.</b>  |  |   |  |
| 24a. REC'D BY REGISTRAR<br><b>NOV 16 '59</b>   |  |   |  | DATE<br><b>NOV 16 '59</b>   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Thoms</b>   |  |   |  | DATE  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12951

CERTIFICATE OF DEATH

12951

Allegany

Allegany

Allegany

West Virginia

U.S.A.

West Virginia

State of West Virginia

Mineral County

November 12, 1951

Allegany

Allegany

Allegany

Nov. 12, 1951

Allegany

USA

Allegany

Allegany

David M. Jones

Allegany

210-01-6051 (Rev. 1-1-50) (G.D. 100-100000-1)

Allegany

Allegany

Allegany

Allegany

Allegany

Allegany

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12052

12094

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |  |  |  |  |  |
|---|-------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> <u>MARYLAND</u>  |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>   |                               |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>  |  |  |  |
| c. LENGTH OF STAY IN 1b <u>5 Wks.</u>   |                               |  |  | d. STREET ADDRESS <u>P.O. Box 59 D.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>  |                               |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>J.</u> Last <u>Komatz</u>  |                               |  |  | 4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1959</u>   |  |  |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 21 1906</u>                 |  | 9. AGE (In years last birthday) <u>53</u> yrs.               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>  |                               |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Market</u> |  | 11. BIRTHPLACE (State or foreign country) <u>Md. Zihlman</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13. FATHER'S NAME <u>Andrew Komatz</u>  |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>Martha Bollinger</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>  |                               | 16. SOCIAL SECURITY NO. <u>217-14-4576</u>   |  | 17. INFORMANT Address <u>Mrs. Ruth Komatz, Eckhart, Md.</u>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chr. glomerular nephritis</u><br><u>445x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Hypertension</u><br>DUE TO (c) <u>Secondary anemia</u> |                               |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1-2 yrs.</u><br><u>2-3 yrs.</u><br><u>6 mos.</u>        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe arterial sclerosis</u>  |                               |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>6-10</u> , 19 <u>59</u> , to <u>11-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>11-8</u> , 19 <u>59</u> , and that death occurred at <u>11:25 P</u> M, from the causes and on the date stated above.  |                               |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>H. C. Diehl</u> M.D.  |                               |  |  | ADDRESS (Street, city or town, state) <u>39 W. Main St. Frostburg, Md.</u>   |  |  |  |
| PHYSICIAN'S NAME (Type) <u>H. C. Diehl, M.D.</u>  |                               |  |  | DATE SIGNED <u>11/10/59</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>11-11-1959</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Eckhart Md.</u>                               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Montan</u> ADDRESS <u>23 East Main, Frostburg, Md.</u>  |                               |  |  | 24a. REC'D BY REGISTRAR <u>NOV 16 '59</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
1700  
CERTIFICATE OF DEATH

|                                   |  |                             |  |                           |  |
|-----------------------------------|--|-----------------------------|--|---------------------------|--|
| 1. Name of deceased               |  | 2. Sex                      |  | 3. Age                    |  |
| 4. Date of death                  |  | 5. Time of death            |  | 6. Place of death         |  |
| 7. Cause of death                 |  | 8. Manner of death          |  | 9. Signature of physician |  |
| 10. Signature of registrar        |  | 11. Signature of informant  |  | 12. Signature of witness  |  |
| 13. Signature of funeral director |  | 14. Signature of undertaker |  | 15. Signature of cemetery |  |
| 16. Signature of health officer   |  | 17. Signature of coroner    |  | 18. Signature of jury     |  |
| 19. Signature of jury             |  | 20. Signature of jury       |  | 21. Signature of jury     |  |
| 22. Signature of jury             |  | 23. Signature of jury       |  | 24. Signature of jury     |  |
| 25. Signature of jury             |  | 26. Signature of jury       |  | 27. Signature of jury     |  |
| 28. Signature of jury             |  | 29. Signature of jury       |  | 30. Signature of jury     |  |
| 31. Signature of jury             |  | 32. Signature of jury       |  | 33. Signature of jury     |  |
| 34. Signature of jury             |  | 35. Signature of jury       |  | 36. Signature of jury     |  |
| 37. Signature of jury             |  | 38. Signature of jury       |  | 39. Signature of jury     |  |
| 40. Signature of jury             |  | 41. Signature of jury       |  | 42. Signature of jury     |  |
| 43. Signature of jury             |  | 44. Signature of jury       |  | 45. Signature of jury     |  |
| 46. Signature of jury             |  | 47. Signature of jury       |  | 48. Signature of jury     |  |
| 49. Signature of jury             |  | 50. Signature of jury       |  | 51. Signature of jury     |  |
| 52. Signature of jury             |  | 53. Signature of jury       |  | 54. Signature of jury     |  |
| 55. Signature of jury             |  | 56. Signature of jury       |  | 57. Signature of jury     |  |
| 58. Signature of jury             |  | 59. Signature of jury       |  | 60. Signature of jury     |  |
| 61. Signature of jury             |  | 62. Signature of jury       |  | 63. Signature of jury     |  |
| 64. Signature of jury             |  | 65. Signature of jury       |  | 66. Signature of jury     |  |
| 67. Signature of jury             |  | 68. Signature of jury       |  | 69. Signature of jury     |  |
| 70. Signature of jury             |  | 71. Signature of jury       |  | 72. Signature of jury     |  |
| 73. Signature of jury             |  | 74. Signature of jury       |  | 75. Signature of jury     |  |
| 76. Signature of jury             |  | 77. Signature of jury       |  | 78. Signature of jury     |  |
| 79. Signature of jury             |  | 80. Signature of jury       |  | 81. Signature of jury     |  |
| 82. Signature of jury             |  | 83. Signature of jury       |  | 84. Signature of jury     |  |
| 85. Signature of jury             |  | 86. Signature of jury       |  | 87. Signature of jury     |  |
| 88. Signature of jury             |  | 89. Signature of jury       |  | 90. Signature of jury     |  |
| 91. Signature of jury             |  | 92. Signature of jury       |  | 93. Signature of jury     |  |
| 94. Signature of jury             |  | 95. Signature of jury       |  | 96. Signature of jury     |  |
| 97. Signature of jury             |  | 98. Signature of jury       |  | 99. Signature of jury     |  |
| 100. Signature of jury            |  | 101. Signature of jury      |  | 102. Signature of jury    |  |



12053

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |  |   |  | c. LENGTH OF STAY IN 1b <b>14 DAYS</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK &amp; MEMORIAL MEMORIAL HOSPITAL AVES.,</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BERNARD</b> Middle <b>M.</b> Last <b>LEESE</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>17</b> Year <b>19 59</b>  |  |  |  |
| 5. SEX <b>MALE</b>   |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>SEPTEMBER 14</b>                                 |  |
| 9. AGE (In years last birthday) <b>60</b>  |  | 10. KIND OF BUSINESS OR INDUSTRY <b>C&amp;A Gas Co.</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>                         |  |
| 13. FATHER'S NAME <b>WILLIAM LEESE</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>MARGARET MC KENZIE</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |  | 16. SOCIAL SECURITY NO. <b>214-05-8195</b>  |  | 17. ADDRESS <b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hodgkins Disease (Abdominal)</b><br><b>201X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Osteomyelitis</b> DUE TO<br>(c) <b>Post-operative shock.</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |  |
| 21. I certify that I attended the deceased from <b>9-9-59</b> to <b>11-17-59</b> , that I last saw the deceased alive on <b>11-17-59</b> , and that death occurred at <b>2:55P.</b> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Thos. D. Williams</b>  |  | ADDRESS (Street, city or town, state) <b>Cumberland Md. 11-19-59</b>                                      |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>DR. W. F. WMS.</b>  |  | DATE SIGNED   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>11-20-59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst,</b>   |  |   |  | ADDRESS <b>Frostburg, Md.</b>  |  | 24a. REC'D BY REGISTRAR <b>NOV 23 '59</b>                            |  |
|  |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12023

ALLEGANY

MARYLAND

ALLEGANY

FREESTONE

IN DAYS

31 SOUTH WATER STREET

WARDEN'S HOSPITAL

GENERAL HOSPITAL

17

NOVEMBER

LEICE

M.

GERARD

NAME WHITE

DECEASED IN

MARYLAND

U.S.A.

VILLIAM LEICE

MARGARET M. LEICE

MENDOTA HOSPITAL, MENDOTA, ILLINOIS

DR. W. F. WOOD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12054

12054

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>11/24/1953</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Edna</b> Last <b>Lindell</b>  |                                  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>2</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/19/1879</b>       |
| 9. AGE (In years last birthday)<br><b>80</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.   | 11. IF UNDER 24 HRS.<br>Hours <b>0</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ownhome</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Wardensville, W. Va.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |   |
| 13. FATHER'S NAME<br><b>Edward T. Cunningham</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annette Cullen</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b>  |                                  | <b>Allegany County Infirmary Records</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.1 Pulmonary Hypostasis</b><br>DUE TO (b) <b>Chronic Myocarditis</b><br>DUE TO (c) <b>Cerebral Arteriosclerosis</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs.</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes Mellitus</b>  |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>11/24/53</b> , 19____, to <b>11/2/59</b> , 19____, that I last saw the deceased alive on <b>11/1/59</b> , 19____, and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>49 Green St. Cumberland, Md.</b> DATE SIGNED <b>11/2/59</b> |                                  |  |   |
| ACTUAL SIGNATURE <b>James E. McLean</b>  |                                  | PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-5-59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fort Ashby Cem.</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Fort Ashby W. Va.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 6 '59</b>   |   |
| ADDRESS<br><b>Cumberland, Md</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |   |

STATE OF ALLEGANY

18054

Allegany

Concordia

11/25/1953

Concordia

Allegany County Infirmary

613 Louisiana Ave.

Mary

Edna

Lincoln

November

Female

White

X

10/19/1953

30

Housewife

Occupation

Edward F. Cunningham

Annette Cullen

Concordia, Md.

Allegany County Infirmary Records

11/25/53

11/25/53

11/25/53

11/25/53

19 Green St.

Concordia, Md.

Dr. James E. Nolan

Post Office Bldg.

Post Office Bldg.

Concordia, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12106

## CERTIFICATE OF DEATH

12055

Reg. Dist. No.

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegheny</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Allegheny</u> b. COUNTY <u>Allegheny</u>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Savage, Md.</u>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>New Row</u>   |                               | d. STREET ADDRESS <u>New Row</u>   |   |
| 3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>F.</u> Last <u>Logsdon</u>   |                               | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1959</u>   |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday) <u>Mar. 4, 1895</u> 54 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Pullman</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O R.R.</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Md. Savage</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |
| 13. FATHER'S NAME <u>Meshaek Logsdon</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Marian Speelman</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>MISS Mary J. Logsdon, Camb Md</u>   |   |
| 17. INFORMANT <u>Miss Mary J. Logsdon, Camb Md</u>  |                               | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac fibrillation</u><br>DUE TO <u>420.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u><br>DUE TO (c) |                               | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u><br><u>10 yrs.</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pulmonary emphysema &amp; fibrosis</u>  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>November 3, 1959</u> , to <u>No. 9</u> , 1959, that I last saw the deceased alive on <u>Nov. 3</u> , 1959, and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <u>Alvin J. Walters</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>48 Broadway, Frostburg, Md.</u> DATE SIGNED <u>11/9/59</u>  |   |
| PHYSICIAN'S NAME (Type) <u>Alvin J. Walters, M. D.</u>  |                               |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>11/10/59</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>  |                               | 22d. LOCATION (City, town or county) (State) <u>Mt. Savage, Md.</u>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James Stein Inc. Camb Md</u> ADDRESS  |                               | 24a. REC'D BY REGISTRAR DATE <u>NOV 12 59</u>  |   |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>   |                               |  |   |



1905

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

12102

|                           |  |                            |  |                           |  |                            |  |
|---------------------------|--|----------------------------|--|---------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED       |  | 2. SEX                     |  | 3. AGE                    |  | 4. PLACE OF BIRTH          |  |
| JAMES H. HARRIS           |  | Male                       |  | 35                        |  | Baltimore, Md.             |  |
| 5. OCCUPATION             |  | 6. CAUSE OF DEATH          |  | 7. PLACE OF DEATH         |  | 8. DATE OF DEATH           |  |
| Clerk                     |  | Heart Disease              |  | Home                      |  | Jan 15, 1905               |  |
| 9. SIGNATURE OF PHYSICIAN |  | 10. SIGNATURE OF WITNESSES |  | 11. SIGNATURE OF DECEASED |  | 12. SIGNATURE OF REGISTRAR |  |
| J. H. Harris              |  | J. H. Harris               |  | J. H. Harris              |  | J. H. Harris               |  |
| 13. PLACE OF INTERMENT    |  | 14. NAME OF CEMETERY       |  | 15. NAME OF MINISTER      |  | 16. NAME OF CHURCH         |  |
| St. Paul's Church         |  | St. Paul's Church          |  | St. Paul's Church         |  | St. Paul's Church          |  |
| 17. NAME OF FUNERAL HOME  |  | 18. NAME OF UNDERTAKER     |  | 19. NAME OF CARRIER       |  | 20. NAME OF DRIVER         |  |
| St. Paul's Church         |  | St. Paul's Church          |  | St. Paul's Church         |  | St. Paul's Church          |  |

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.



12055

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>6 DAYS</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JAMES</b> Middle <b>LOGSDON</b> Last   |  |   |  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>7</b> Year <b>19 59</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>WHITES</b>         |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JUNE 14, 1878</b>                                    |  |
| 9. AGE (In years lost birthday)<br><b>81 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired crossing</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>W. Md. Rwy.</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Frostburg, Maryland</b>     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>JAMES LOGSDON</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Yates</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>705-10-8191</b>   |  |   |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>   |  |   |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Nephritis &amp; Chronic myocardial</b><br><b>592x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ravages at age</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>1-22-</b> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |   |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I attended the deceased from <b>8/7/57</b> , 19___, to <b>11/7/59</b> , 19___, that I last saw the deceased alive on <b>11/6/59</b> , 19___, and that death occurred at <b>12:35 A.M.</b> from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>R. J. Williams, M.D.</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>Cumberland Md.</b>   |  |   |  |
| DATE SIGNED<br><b>11/7/59</b>  |  |   |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. R. J. WILLIAMS</b>   |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>11/9/59</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Memorial Pk.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b>   |  |   |  | ADDRESS<br><b>Cumberland, Md.</b>   |  |   |  |
| 24a. REC'D BY REGISTRAR<br><b>NOV 10 59</b>  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Kraus</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12025

CERTIFICATE OF DEATH

ALLIED

WILLIAM

ALLIED

CUMBERLAND

6 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

323 QUEEN STREET

NOVEMBER 1

1900

JAMES

WHITE

JUNE 11, 1910

U.S.A.

JAMES LORRY

1902-11-01 MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

DR. B. J. WILLIAMS

11/1/00

Porter L. George Cumberland, No. 1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12057

Reg. Dist. No.

12056

FOR STATE  
HEALTH DEPT.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |   | c. LENGTH OF STAY IN 1b<br><b>64 yrs.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>904 Michigan Ave.</b>   |   | e. STREET ADDRESS<br><b>904 Michigan Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>John Martin Mantheyi</b>   |   | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>14</b> Year <b>19 59</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 25, 1895</b>                                |
| 9. AGE (In years last birthday)<br><b>64 yrs.</b>  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Pipe Fitter</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>John Mantheyi</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hooft</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>yes War I</b>  |   | 16. SOCIAL SECURITY NO.<br><b>705-05-773</b>   |   |
| 17. INFORMANT<br><b>Mrs. Mary F. Browning, Baltimore, Md.</b>  |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertensive Disease</b><br>DUE TO (c)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>sudden</b><br><b>years?</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE <b>Benedict Skitareli</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <b>Benedict Skitareli c MD</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | DATE SIGNED <b>Nov. 17, 1959</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>Nov. 19, 1959</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Mary's Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 19 '59</b>  |   |
|  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
12057 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 2, 11. See: Birth Cert. et  
CERTIFICATE OF DEATH

12058

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Pennsylvania</b> b. COUNTY <b>Bedford</b>           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>41 MINUTES</b>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HYNDMAN, PA.</b>  |                                  | 75 x-3   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>   |                                  | d. STREET ADDRESS<br><b>ROUTE #1</b>   |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BABY</b> Middle <b>BOY</b> Last <b>MARGRAFF</b>  |                                  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>1</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>NOVEMBER 1, 1959</b> |
| 9. AGE (In years lost birthday) yrs.   |                                  | 10. IF UNDER 1 YEAR Months Days Hours  |   |
| 11. IF UNDER 24 HRS. Mins.   |                                  | <b>41</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>ROBERT S. MARGRAFF</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>SARA M. SHIREY</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |   |
| INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b>   |                                  | <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>761.5</b> DUE TO <b>Prematurity</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Partial separation of Placenta</b><br>DUE TO (c) |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Nov. 1, 1959</b> to <b>Nov. 1, 1959</b> , that I last saw the deceased alive on <b>Nov. 1, 1959</b> , and that death occurred at <b>2:45 AM</b> , from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE<br><b>W. R. Hodges</b>  |                                  | ADDRESS (Street, City or town, State)<br><b>Cumberland, Md.</b>  |   |
| DATE<br><b>11/1/59</b>   |                                  | DATE SIGNED  |   |
| PHYSICIAN'S NAME (Type)<br><b>DR. W. R. HODGES</b>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-1-59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hyndman</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hyndman, Pa</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harvey H. Zeigler</b>   |                                  | ADDRESS<br><b>Hyndman, Pa</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>NOV 13 '59</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |   |

2060244XVI

12057

CERTIFICATE OF DEATH

12057

ALLDAY

CLEVELAND

11 MINUTES

HYGIENIC, PA.

GENERAL HOSPITAL

ROUTE 11

BABY BOY MARGARET

NOVEMBER 1

22

DATE WHITE

NOVEMBER 1, 1952

ROBERT S. MARGARET

SARA M. CUREY

MEMORIAL HOSPITAL - CLEVELAND, OH.  
WARRICK & MEMORIAL AVENUE

DR. J. R. HODGES

*[Faint, illegible handwritten text at the bottom of the page]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12059

Reg. Dist. No.

12058

|   |  |   |  |   |   |  |   |
|---|--|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |  |   | c. LENGTH OF STAY IN 1b<br><b>35 yrs.</b>  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>101 Pennsylvania Ave.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Drucille</b> Last <b>Merrill</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>20</b> Year <b>19 59</b>   |   |  |   |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>                  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>April 10, 1878</b>  |   |
| 9. AGE (In years last birthday)<br><b>81</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>10</b> |  | IF UNDER 24 HRS.<br>Hours <b>10</b> Min. <b>15</b>  |   |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |   | 11. BIRTHPLACE (State or foreign country)<br><b>New Germany, Md.</b>                                     |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |   |   |  |   |
| 13. FATHER'S NAME<br><b>Samuel D. Hummel</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Tate</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>no</b>  |   | 17. INFORMANT<br><b>Mr. Harry Merrill, Baltimore, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure, Chronic Myocarditis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic CV disease</b><br>(c) <b>Arteriosclerotic CV disease</b><br>DUE TO<br>cause lost.  |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 Wks</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Terminal Bronchopneumonia; Uremia; Fractured hip, wrist</b>   |  |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell at home</b>  |   |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>10:00 a.m. Oct. 29 1959</b>   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b> |  | 20f. (City or town) (County) (State)<br><b>Cumberland, Alleg. Md.</b>                             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |   |   |  |   |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |
| EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, MD</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Nov. 21, 1959</b>  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>11-23-59</b>              |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                                  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br><b>Nov 25 59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |   |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br><b>JOHN J. BROWN</b>        |  | 2. SEX<br><b>MALE</b>                            |  | 3. AGE<br><b>45</b>                             |  |
| 4. OCCUPATION<br><b>LABORER</b>                    |  | 5. PLACE OF BIRTH<br><b>MASSACHUSETTS</b>        |  | 6. DATE OF BIRTH<br><b>1910</b>                 |  |
| 7. PLACE OF DEATH<br><b>HOME</b>                   |  | 8. DATE OF DEATH<br><b>1955</b>                  |  | 9. TIME OF DEATH<br><b>10:00 AM</b>             |  |
| 10. CAUSE OF DEATH<br><b>HEART DISEASE</b>         |  | 11. MANNER OF DEATH<br><b>NATURAL</b>            |  | 12. SIGNATURE OF EXAMINER<br><b>[Signature]</b> |  |
| 13. SIGNATURE OF NEXT OF KIN<br><b>[Signature]</b> |  | 14. SIGNATURE OF PHYSICIAN<br><b>[Signature]</b> |  | 15. SIGNATURE OF CLERK<br><b>[Signature]</b>    |  |
| 16. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 17. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 18. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 19. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 20. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 21. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 22. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 23. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 24. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 25. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 26. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 27. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 28. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 29. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 30. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 31. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 32. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 33. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 34. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 35. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 36. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 37. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 38. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 39. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 40. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 41. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 42. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 43. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 44. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 45. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 46. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 47. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 48. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 49. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 50. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 51. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 52. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 53. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 54. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 55. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 56. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 57. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 58. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 59. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 60. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 61. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 62. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 63. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 64. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 65. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 66. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 67. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 68. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 69. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 70. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 71. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 72. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 73. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 74. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 75. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 76. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 77. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 78. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 79. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 80. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 81. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 82. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 83. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 84. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 85. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 86. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 87. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 88. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 89. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 90. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 91. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 92. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 93. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 94. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 95. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 96. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 97. SIGNATURE OF JURY<br><b>[Signature]</b>        |  | 98. SIGNATURE OF JURY<br><b>[Signature]</b>      |  | 99. SIGNATURE OF JURY<br><b>[Signature]</b>     |  |
| 100. SIGNATURE OF JURY<br><b>[Signature]</b>       |  | 101. SIGNATURE OF JURY<br><b>[Signature]</b>     |  | 102. SIGNATURE OF JURY<br><b>[Signature]</b>    |  |



## CERTIFICATE OF DEATH

Reg. Dist. No.

12059

|   |                                  |   |   |   |  |   |   |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  |   | c. LENGTH OF STAY IN 1b<br><b>22 DAYS</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b> |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR IN <b>MEMORIAL HOSPITAL</b><br><b>MEMORIAL &amp; WARWICK AVES.</b>  |                                  |   |   | d. STREET ADDRESS<br><b>1 206 PARK STREET</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>W.</b> Last <b>MEYERS</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>27</b> Year <b>19 59</b>   |  |   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 3, 1917</b>   |   | 9. AGE (In years last birthday)<br><b>42</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>WISCONSIN, LaCrosse</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILLIAM MEYERS</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>GENEVIEVE <del>XXXXXX</del> Flaherty</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service) <b>WW 11 219-03-9599</b>  |   | INFORMANT<br><b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MARYLAND</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC Coma</b><br><b>581.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>LAENNEC'S CIRRHOSIS</b> DUE TO<br>(c) _____   |                                  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>MALNUTRITION</b>  |                                  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>23 Oct</b> , 19 <b>58</b> , to <b>27 NOV</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>27 NOV</b> , 19 <b>59</b> , and that death occurred at <b>6:35 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>N. Smallwood St. Cumberland, Maryland</b> DATE SIGNED <b>11/28/59</b> |                                  |   |   |   |  |   |   |
| ACTUAL SIGNATURE <b>L.M. Glick</b>  |                                  | M.D. <b>N. Smallwood St. Cumberland, Md.</b>  |   |   |  |   |   |
| PHYSICIAN'S NAME (Type) <b>DR. M. GLICK</b>   |                                  | M.D. <b>N. Smallwood St. Cumberland, Md.</b>  |   |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/30/59</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Mem. Park</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>                      |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>  |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>DEC 4 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Curtis L. Kraus</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CONFIDENTIAL

U.S. AIR FORCE, WASHINGTON, D.C.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12061

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 12060   |                                  | Reg. Dist. No.   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegheny County</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Cumberland</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>02 0 Cumberland Md.</u>   |  |
| c. LENGTH OF STAY IN 1b   |                                  | d. STREET ADDRESS<br><u>609 Elm St.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Memorial Hospital</u>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>John Edgar Miller</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Nov.</u> Day <u>25</u> Year <u>1959</u>   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>June 27, 1871</u> |
| 9. AGE (In years last birthday)<br><u>88</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired Dry Cleaner</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Cleaning &amp; Dying</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Johnsville, Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>William Miller</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Adelaide McClellan</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><u>Ne</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |  |
| 17. INFORMANT<br><u>Mrs. John R. Dorn</u>   |                                  | Address<br><u>Cumb. Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u><br/> <u>422.1</u> DUE TO<br/>           Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u><br/>           DUE TO (c) <u>  </u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH<br/> <u>  </u><br/> <u>  </u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br/> <u>Fracture of Left hip</u></p> |                                  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Fell at home</u>                                      |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><u>9:00</u> Hour <u>Nov 19</u> 19 <u>59</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>                                     |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   |                                  | 20f. (City or town) (County) (State)<br><u>Cumberland, Alleg. Md.</u>  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                                  |  |  |
| ACTUAL SIGNATURE<br><u>Benedict Skitarelic</u>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><u>Benedict Skitarelic, M.D.</u>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                  | DATE SIGNED<br><u>November 25, 1959</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>11/28/59</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Hillcrest Cem.</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Cumberland Md.</u>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Louis Stein Inc.</u>   |                                  | 24a. REC'D BY REGISTRAR<br><u>DEC 1 '59</u>  |  |
| ADDRESS<br><u>Cumb. Md.</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>Arthur S. Kline</u>   |  |







TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12062

12107

Reg. Dist. No.

|   |                                  |   |                                     |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. <b>Maryland</b> b. COUNTY <b>Allegany</b>                       |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Nikep</b>  | c. LENGTH OF STAY IN 1b          | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Nikep</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                  | d. STREET ADDRESS   |                                     |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                     |
| 3. NAME OF DECEASED (Type or print)<br>First MARY Middle A. Last MOFFATT  |                                  | 4. DATE OF DEATH<br>Month 11/30/1959 Day Year 19  |                                     |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>7/3/1892</b> |
| 9. AGE (In years last birthday)<br><b>67</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework Own Home</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                     |
| 11. BIRTHPLACE (State or foreign country)<br><b>Barton, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                     |
| 13. FATHER'S NAME<br><b>Charles Howell</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Eagen</b>   |                                     |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                     |
| 17. INFORMANT<br><b>Mr. Richard Moffatt SR. Nikep, MD.</b>  |                                  | Address   |                                     |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial Insufficiency</b><br><b>422.2</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 years</b> |                                  |   |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                                  |   |                                     |
| ACTUAL SIGNATURE<br><b>W O McLane</b>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                     |
| EXAMINER'S NAME (Type)<br><b>W O McLane M.D.</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                     |
|   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                     |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>12/2.1959</b>   |                                     |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Hill Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Moscow, Maryland</b>  |                                     |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>George Cickhom, Funerals, Inc.</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 2 '59</b>  |                                     |
|   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Kraus</b>  |                                     |

DATE SIGNED

**Nov 30/1959**

1003

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

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12061

CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>                    |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>59 days</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mary</b> Middle <b>Viola</b> Last <b>Moomaw</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>29</b> Year <b>1959</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>11-21-1891</b>         |  |
| 9. AGE (In years last birthday)<br><b>68</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>6</b> Hours <b>6</b> Min. |  | 11. BIRTHPLACE (State or foreign country)<br><b>Mo.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Isaac</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Verdie Barns</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |   |  |
| 17. INFORMANT<br><b>Pt's Chart</b>   |  |  |  | Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Cecum c</b><br><b>153.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19 _____  |  |  |  |   |  |   |  |
| 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |   |  |   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |   |  |   |  |
| 20f. (City or town) (County) (State)   |  |  |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>10-5</b> , 19 <b>59</b> , to <b>11-29</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11-28</b> , 19 <b>59</b> , and that death occurred at <b>6:50 P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Charles L. George</b> M.D.   |  |  |  |   |  |   |  |
| PHYSICIAN'S NAME (Type)  |  |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |   |  |   |  |
| 22b. DATE THEREOF<br><b>12-1, 1959</b>   |  |  |  |   |  |   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baptist Cem.</b>  |  |  |  |   |  |   |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Three Churches, W. Va.</b>   |  |  |  |   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>  |  |  |  |   |  |   |  |
| 24a. REC'D BY REGISTRAR<br><b>DEC 2 '59</b>  |  |  |  |   |  |   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kline</b>   |  |  |  |   |  |   |  |

CERTIFICATE OF DEATH

12081

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## CERTIFICATE OF DEATH

Reg. Dist. No.

12064

12062

|   |                              |   |  |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>2yrs</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Oldtown Road</b>   |                              | d. STREET ADDRESS<br><b>Oldtown Road</b>  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Emma</b> Middle <b>J.</b> Last <b>Moore</b>   |                              | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>28</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 15, 1871</b>   |
| 9. AGE (In years last birthday)<br><b>78</b> yrs.   |                              | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ownhome</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Belington W.Va.</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Daniel Ice</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Emily Poling</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Ida B. Brake</b>  |                              | Address<br><b>Oldtown Road</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>Hypertensive C.V.D.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Hypertensive C.V.D.</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Advanced age</b> |                              |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>11/12/59</b> , 19____, to <b>11/28/59</b> , 19____, that I last saw the deceased alive on <b>11/28/59</b> , 19____, and that death occurred at <b>10:15</b> M., from the causes and on the date stated above.  |                              |   |  |
| ACTUAL SIGNATURE<br><b>Richard J. Williams</b> M.D.   |                              | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Cumberland, Md. 11/28/59</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>Richard J. Williams</b>   |                              | <b>I22 S. Centre St Cumberland, Md.</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>I2-I-59</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Maplewood Cem.</b>   |                              | 22d. LOCATION (City, town, or county) (State)<br><b>Elkins, W.Va.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |                              | 24a. REC'D BY REGISTRAR<br><b>DEC 2 '59</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Arthur E. Reed</b>   |                              |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1200

DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1200

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Married

Single

Widow

Divorced

Never married

Previously married

Never married

Previously married

Never married

Previously married

Never married

Previously married

RECEIVED BY THE DEPARTMENT OF HEALTH - BALTIMORE 10  
DATE  
TIME  
PLACE  
CAUSE  
MANNER  
AGE  
SEX  
RACE  
EDUCATION  
OCCUPATION  
RELIGION  
Married  
Single  
Widow  
Divorced  
Never married  
Previously married  
Never married  
Previously married  
Never married  
Previously married  
Never married  
Previously married



12063

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |                                    |   |   |  |  |
|---|----------------------------------|---|------------------------------------|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  |   |                                    | c. LENGTH OF STAY IN 1b<br><b>20 days</b>   |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>  |                                  |   |                                    | d. STREET ADDRESS<br><b>194 N. Centre St.</b>   |   |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |                                    |   |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Barbara</b> Middle <b>E.</b> Last <b>Mudd</b>   |                                  | 4. DATE OF DEATH<br>Month <b>11/</b> Day <b>13/</b> Year <b>19 59</b>   |                                    |   |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>5/30/84</b> | 9. AGE (In years last birthday)<br><b>75</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Ownhome (Domestic)</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland Cumberland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                |  |
| 13. FATHER'S NAME<br><b>William Hodel</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Barbara McMann</b>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>578-26-4720</b>   |                                    | INFORMANT<br><b>Chart.</b>  |   | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____ DUE TO<br>(c) <b>Nutritional anemia</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                  |   |                                    |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b><br><b>1 year</b>          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>3 - 14</b> , 19 <b>58</b> , to <b>11-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11 - 12</b> , 19 <b>59</b> , and that death occurred at <b>2:15 A.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b> DATE SIGNED <b>11-13-59</b>   |                                  |   |                                    |   |   |  |  |
| ACTUAL SIGNATURE <b>Ralph W. Ballin,</b>  |                                  | M.D. <b>62 Greene St. Cumberland, Md.</b>   |                                    |   |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>  |                                  |   |                                    |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>II-16-59</b>  |                                    | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick Cem</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli Cumberland, Md.</b>   |                                  |   |                                    | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 17 '59</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                         |  |

062

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1

22

CERTIFICATE OF DEATH

1900

1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12066

Reg. Dist. No.

|  |  |  |   |   |  |   |   |  |
|--|--|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b> MARYLAND  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |  |  | c. LENGTH OF STAY IN 1b<br><b>10 Days</b>                   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland</b> |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>   |  |  |   | d. STREET ADDRESS<br><b>727 Bedford Street</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>EARL</b> Middle <b>R.</b> Last <b>MURRAY</b>   |  |  |   | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>14</b> Year <b>19 59</b>   |  |   |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>April 24, 1887</b>   |   |  |
| 9. AGE (In years last birthday)<br><b>72</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |   | IF UNDER 24 HRS.<br>Hours Min.  |  |   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Mach.</b>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B. &amp; O R.R.</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland, Hancock</b>                                    |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Edgar Murray</b>   |  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ella <del>Hogok</del> Brady</b>  |  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address<br><b>Memorial Hospital Cumberland, Md.</b>   |  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage and Edema</b><br>DUE TO <b>900-0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Skull Fracture</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>10 Days</b><br><b>10 Days</b>                         |  |  |   |   |  |   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic Myocarditis, Terminal Pneumonia</b> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell Down Steps At Home</b> |   |   |  |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m.<br><b>11:00 Nov. 4 1959</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>           |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>   |  | 20f. (City or town) (County) (State)<br><b>Cumberland, Alleg. Md.</b>                             |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |  |   |   |  |   |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.   |  |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>  |  |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |   |  |
|  |  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Nov. 14, 1959</b>  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>Nov. 16, 1959</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>                      |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>   |  |  |   | 24a. REC'D BY REGISTRAR<br><b>NOV 18 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Frank</b>  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

12000

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                                       |  |                                 |  |  |  |   |  |                                 |  |
|---------------------------------------|--|---------------------------------|--|--|--|---|--|---------------------------------|--|
| NAME OF DECEASED<br>JAMES E. BAKER    |  | AGE<br>65                       |  | SEX<br>Male                              |  | RACE<br>White                               |  | DATE OF DEATH<br>April 12, 1947 |  |
| PLACE OF DEATH<br>Home                |  | CITY<br>Baltimore               |  | COUNTY<br>Baltimore                      |  | STATE<br>Maryland                           |  | ZIP CODE<br>21201               |  |
| OCCUPATION<br>Retired                 |  | EDUCATION<br>High School        |  | RELIGION<br>Methodist                    |  | MARRIAGE<br>Married                         |  | SPOUSE<br>Mary E. Baker         |  |
| CAUSE OF DEATH<br>Heart Disease       |  | MANNER OF DEATH<br>Natural      |  | IMMEDIATE CAUSE<br>Myocardial Infarction |  | UNDERLYING CAUSE<br>Coronary Artery Disease |  | OTHER CAUSE<br>None             |  |
| DATE OF EXAMINATION<br>April 12, 1947 |  | TIME OF EXAMINATION<br>10:00 AM |  | PLACE OF EXAMINATION<br>Home             |  | NAME OF EXAMINER<br>J. E. Smith             |  | SIGNATURE<br>J. E. Smith        |  |
| DATE OF REPORT<br>April 12, 1947      |  | TIME OF REPORT<br>10:00 AM      |  | PLACE OF REPORT<br>Home                  |  | NAME OF REPORTER<br>J. E. Smith             |  | SIGNATURE<br>J. E. Smith        |  |
| DATE OF CERTIFICATE<br>April 12, 1947 |  | TIME OF CERTIFICATE<br>10:00 AM |  | PLACE OF CERTIFICATE<br>Home             |  | NAME OF CERTIFIER<br>J. E. Smith            |  | SIGNATURE<br>J. E. Smith        |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12065

CERTIFICATE OF DEATH

Reg. Dist. No.

12067

|   |                                  |  |                                      |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>10/21/59</b>   |                                      |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Allegany County Infirmary</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Michael</b> Middle <b>Paul</b> Last <b>Murray</b>   |                                  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>5</b> Year <b>19 59</b>   |                                      |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/5/1873</b> |
| 9. AGE (In years last birthday)<br><b>86</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.  |                                      |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - Kelly Springfield Tire Co. Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                      |
| 13. FATHER'S NAME<br><b>Robert Murray</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Bridget Cosgrove</b>  |                                      |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, army, navy, etc.)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b>   |                                      |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>592x</b> DUE TO <b>Chronic Myocarditis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis</b><br>(c) <b>Chronic Hepatitis</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Serious Mental Depression</b>   |                                  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that I attended the deceased from <b>10/21/59</b> , 19____, to <b>11/5/59</b> , 19____, that I last saw the deceased alive on <b>11/5/59</b> , 19____, and that death occurred at <b>6:12 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>11/6/59</b> |                                  |  |                                      |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.  |                                  | PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b> <b>Cumberland, Md.</b>  |                                      |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11-8-59</b>  |                                      |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Peter &amp; Paul Cem.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>  |                                      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>NOV 12 1959</b>  |                                      |
| ADDRESS<br><b>Cumberland, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. S. Knap</b>  |                                      |

12003

CERTIFICATE OF DEATH

12003

Allegheny

Maryland

Allegheny

Cumberland

10/21/39

Cumberland

103 Hayes James

Allegheny County

103 Hayes James

103 Hayes James

103 Hayes James

103 Hayes James

86

103 Hayes James

103 Hayes James

103 Hayes James

U. S. A.

Allegheny County

103 Hayes James

103 Hayes James

Cumberland, Md.

103 Hayes James

Allegheny County

11/2/39

10/21/39

11/2/39

11/2/39

103 Hayes James

Cumberland, Md.

Dr. James E. Nelson



|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>  |  |   |  | c. LENGTH OF STAY IN 1b <b>8/29/59</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | d. STREET ADDRESS <b>Rt. 1, Valley Road</b>                               |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Gideon</b> Last <b>Nazelrod</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>5</b> Year <b>19 59</b>   |  |   |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>6/29/1891</b>   |  |
| 9. AGE (In years last birthday) <b>68</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>8</b> Hours <b>15</b> Min. |  | 11. IF UNDER 24 HRS.<br>Hours <b>15</b> Min.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentering</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>            |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |   |  |  |  |   |  |
| 13. FATHER'S NAME <b>John Nazelrod</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>Catherine Cleaver</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO. <b>INFORMANT P.O.Box 599</b> Address <b>Cumberland, Md.</b>  |  |   |  |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>350x Pulmonary Hypostasis</b><br>DUE TO (b) <b>General Arteriosclerosis</b><br>DUE TO (c) <b>Paralysis agitans</b>        |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophic Arthritis</b>   |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b><br>p. m.  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |   |  |
| 21. I certify that I attended the deceased from <b>8/29/59</b> , 19____, to <b>11/5/59</b> , 19____, that I last saw the deceased alive on <b>11/5/59</b> , 19____, and that death occurred at <b>6:40 PM</b> , from the causes and on the date stated above. |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>James E. McLean</b>   |  |   |  | ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>  |  |   |  | DATE SIGNED <b>11/6/59</b>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>11/9/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Meth. Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Spring Gap. Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>  |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 12 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Carlton S. Thomas</b>                    |  |

13068

MAINE AND SYDNEY DEPARTMENT OF HEALTH - BIRTH RECORDS

CERTIFICATE OF DEATH

13068

Allegany

Maryland

Allegany

Chamberland

6/22/59

Chamberland

Box 1, Valley Road

Allegany County Jail

November 22, 1959

Robert Gibson

Robert

68

6/22/1991

White

Male

U. S. A.

West Virginia

Chamberland

Notified Chamberland

Dorothy Cleaver

John Hessler

Chamberland, Md.

P.O. Box 202

Allegany County Jail

11/5/59

6/22/59

11/5/59

11/5/59

19 Avenue 22

Chamberland, Md.

Gr. James H. Holsen

Chamberland, Md. Chamberland, Md.

John A. Holsen, Chamberland, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12067  
CERTIFICATE OF DEATH

12069

Reg. Dist. No.

|   |                                  |  |   |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>6 DAYS</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOVENIA</b> Middle <b>NIXON</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>7</b> Year <b>1959</b>  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPT. 24, 1863</b> |
| 9. AGE (In years lost birthday)<br><b>96</b> yrs.   |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>CHRISTOPHER BARTH</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MARION WISHMYER</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>  |                                  | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Failure</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Myocardial Infarction</b><br>(c) <b>Arteriosclerotic Heart Disease</b> |                                  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old cerebral infarction, left</b>  |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>1 NOV, 1959</b> to <b>7 NOV, 1959</b> , that I last saw the deceased alive on <b>7 NOV, 1959</b> , and that death occurred at <b>1:15 AM</b> , from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE <b>Dr. Weisman</b>   |                                  | DATE SIGNED <b>11/13/59</b>  |   |
| PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>  |                                  | ADDRESS <b>Cumberland, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Nov. 9, 1959</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olive Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Oldtown, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Kight</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 16 '59</b>  |   |
| ADDRESS<br><b>Cumberland, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Charles E. Kraus</b>  |   |

060

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TESTING CASE ORIGIN

13063

13063

ALLGARY

INRYLAND

ALLGARY

INRYLAND

6 DAYS

GLTOWL, MD.

HOSPITAL

ADVENTA

INION

INION

WHITE

13

SEPT. 21, 1966

INRYLAND

INRYLAND

CHRISTOPHER MARTIN

MARTIN MARTIN

HE-ORAL HOSPITAL - CLINICAL AND SURGICAL

DR. NELSON

DR. NELSON

DR. NELSON

1  
 M  
 12068  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

Reg. Dist. No.

12070

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND,</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>22 DAYS</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VIRGINIA</b> Middle <b>R.</b> Last <b>OSWALD</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1959</b>   |  |  |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>DECEMBER 25</b>                                   |  |
| 9. AGE (In years last birthday)<br><b>64</b> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>—  |  | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>WILLIAM MILLNOR ROBERTS</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>FANNY MILLHOLLAND</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br>—  |  |  |  |
| 17. ADDRESS<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>   |  |   |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinomatosis Generalized</b><br>DUE TO <b>153.8</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Adeno Carcinoma Sigmoid</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br>19   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>59</b> , to <b>5 Nov</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5 Nov</b> , 19 <b>59</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Cumberland Md.</b> DATE SIGNED <b>7 Nov 59</b><br>ACTUAL SIGNATURE <b>Fuller B Whitworth</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>DR. FULLER WHITWORTH</b>   |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 22b. DATE THEREOF   |  | 22c. NAME OF CEMETERY OR CREMATORY  |  | 22d. LOCATION (City, town, or county) (State)                            |  |
| <b>Burial</b>   |  | <b>11/7/59</b>  |  | <b>Rose Hill Cem.</b>   |  | <b>Cumberland Md.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James S. Inc. - Cumberland Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 9 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>                      |  |

# CERTIFICATE OF DEATH

11088

ALLGANY

MARYLAND

CHESBROUGH

SS DAYS

CHESBROUGH

MEMORIAL HOSPITAL  
BARRICK & MEMORIAL  
AVES. 504 GREENE STREET

VIRGINIA

COALD

MUSKIEE

WHITE

OCTOBER 23

PA

CHESBROUGH, MARYLAND

FAMILY WILLHOLAND

WILLIAM MILLER ROBERTS

MEMORIAL HOSPITAL, CHESBROUGH, MARYLAND

DR. CLAUDE W. WILKINSON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12069 CERTIFICATE OF DEATH

12071

Reg. Dist. No.

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>9 DAYS</b>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL CUMBERLAND</b>  |                                  | d. STREET ADDRESS<br><b>ROUTE 3 VALLEY ROAD</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>MEMORIAL HOSPITAL<br/>MEMORIAL &amp; WARWICK AVES.</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WAITMAN</b> Middle <b>H.</b> Last <b>PHILLIPS</b>  |                                  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>30</b> Year <b>1959</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 2, 1893</b> |
| 9. AGE (In years last birthday)<br><b>66</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Celanese employee</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>WEST VIRGINIA</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN PHILLIPS</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>CECELIA WALTMAN</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-05-9685</b>   |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL</b>  |                                  | Address<br><b>CUMBERLAND, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b><br>DUE TO <b>Coronary occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Uremia</b><br>DUE TO <b>Cardiac decompensation</b><br>(c) <b>Generalized arteriosclerosis</b>   |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Nov</b> , 1954, to <b>11/30</b> , 1959, that I last saw the deceased alive on <b>11/30</b> , 1959, and that death occurred at <b>4:00PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Allegany Hotel 124-2107</b><br>DATE SIGNED <b>C. H. H. H.</b><br>ACTUAL SIGNATURE <b>George M. Simon</b> M.D.<br>PHYSICIAN'S NAME (Type) <b>DR. GEORGE SIMONS</b> |                                  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>December 3, 1959</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sunset Memorial Park</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md. Bedford Road</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Harvey T. Legler</b>  |                                  | ADDRESS<br><b>Hyndman, Pa.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>DEC 4 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |  |

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12088

CERTIFICATE OF DEATH

WEST VIRGINIA DEPARTMENT OF HEALTH

12088

ALLEGANY

MARTINSBURG

ALLEGANY

CO. 100

9 DAYS

RURAL

GREENSBORO

WEST VIRGINIA HOSPITAL  
CLINICAL & AMBULANCE A.S.

ROUTE 2 VALLEY ROAD

WATKINS

H.

WILLIAMS

HONOLULU

MAY 2, 1933

WHITE

MALE

WEST VIRGINIA

JOHN PHILLIPS

REBECCA WATKINS

WEST VIRGINIA HOSPITAL  
CLINICAL & AMBULANCE A.S.

DR. GEORGE SIMON

12088

1  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12070**  
**CERTIFICATE OF DEATH**

12072

Reg. Dist. No.

|  |                               |  |                                      |   |  |  |                             |
|--|-------------------------------|--|--------------------------------------|---|--|--|-----------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>ALLEGANY</b> MARYLAND  |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |  |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>   |                               |  |                                      | c. LENGTH OF STAY IN 1b <b>2 DAYS</b>   |  |  |                             |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR <b>MEMORIAL HOSPITAL</b><br><b>MEMORIAL &amp; WARWICK AVES.</b>   |                               |  |                                      | d. STREET ADDRESS <b>939 GAY STREET</b>   |  |  |                             |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                      |   |  |  |                             |
| 3. NAME OF DECEASED (Type or print)  |                               | First <b>LEE</b> Middle <b>VERNON</b> Last <b>POORBAUGH</b>  |                                      | 4. DATE OF DEATH  |  | Month <b>NOVEMBER</b> Day <b>25</b> Year <b>1959</b>             |                             |
| 5. SEX <b>MALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>JUNE 21 1907</b> |   | 9. AGE (In years lost birthday) <b>52</b> yrs. | IF UNDER 1 YEAR Months Days                                      | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. Beaming</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Textile Mill</b>  |                                      | 11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                       |                             |
| 13. FATHER'S NAME <b>ELI POORBAUGH</b>   |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <b>LAURA SMITH</b>   |  |  |                             |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |                               | 16. SOCIAL SECURITY NO. <b>214-07-2615</b>   |                                      | INFORMANT <b>MEMORIAL HOSPITAL</b> Address <b>CUMBERLAND, MARYLAND</b>  |  |  |                             |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>410X</b> DUE TO <b>Acute Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardic Stenosis - Mitral Insufficiency</b><br>(c) _____ |                               |  |                                      | INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>   |  |  |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                               |  |                                      |   |  |  |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |   |  |  |                             |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                             |                             |
| 21. I certify that I attended the deceased from <b>July 25</b> , 19 <b>58</b> , to <b>Nov 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov 25</b> , 19 <b>59</b> , and that death occurred at <b>7:20 P.M.</b> , from the causes and on the date stated above.   |                               |  |                                      |   |  |  |                             |
| ACTUAL SIGNATURE <b>[Signature]</b>  |                               | M.D. <b>133 Va Ave, Cumberland, Md</b>   |                                      | ADDRESS (Street, city or town, state)   |  | DATE SIGNED <b>11/27/59</b>                                      |                             |
| PHYSICIAN'S NAME (Type) <b>DR. HIMMELWRIGHT</b>  |                               |  |                                      |   |  |  |                             |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>11-30-59</b>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY <b>Everett Cem.</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Everett Pa.</b> |                             |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b> ADDRESS <b>Cumberland, Maryland</b>   |                               |  |                                      | 24a. REC'D BY REGISTRAR <b>DEC 2 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>                |                             |

MEDICAL CERTIFICATION

CERTIFICATE OF BIRTH

1907

ALLIANCE

WYOMING

ALLIANCE

2 DAYS

WYOMING

223 GAY STREET

MEMORIAL HOSPITAL  
MEMORIAL & WYOMING AVENUE

WYOMING

WYOMING

WYOMING

WYOMING

JUNE 21 1907

WHITE

WYOMING

WYOMING

WYOMING

WYOMING

Laura Smith

ELI POORE

WYOMING

MEMORIAL HOSPITAL

*Handwritten signatures and notes*

DR. HAZELWRIGHT

12071  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

12073

Reg. Dist. No.

|  |                                  |   |   |   |  |  |  |
|--|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>2 HOURS</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 CUMBERLAND</b> |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>  |                                  |   |   | d. STREET ADDRESS<br><b>251 WILLIAM STREET</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>AGNES</b> Middle <b>C.</b> Last <b>PRATT</b>   |                                  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1959</b>   |   |   |  |  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 8. DATE OF BIRTH<br><b>DECEMBER 28 1896</b>   |  | 9. AGE (In years last birthday) <b>62</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk &amp; Owner</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Grocery Store</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>JACOB MINKE</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>CHATERINE ROBINSON</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-22-4373</b>   |   | INFORMANT Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>331X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) <b>Hypertension</b> |                                  |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 da.</b><br><b>10 yr.</b><br><b>2 yr.</b>              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>  |                                  |   |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>   |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>March 1, 1959</b> to <b>November 2, 1959</b> , that I last saw the deceased alive on <b>November 2, 1959</b> , and that death occurred at <b>6:00A</b> AM, from the causes and on the date stated above.  |                                  |   |   |   |  |  |  |
| ACTUAL SIGNATURE <b>James F. Hallinan</b>  |                                  |   |   | ADDRESS (Street, city or town, state)<br><b>140 Bedford Street</b>  |  | DATE SIGNED<br><b>11/2/59</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>DR. JAMES HALLINAN</b>   |                                  |   |   | <b>Cumberland, Maryland</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11-5-1959</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Patrick's Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli, Cumberland, Md.</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 6 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>   |  |

13078

CERTIFICATE OF DEATH

13071

ALLEGEDLY

2 HOURS

WILLIAM STREET

PRATT

DECEMBER 28, 1902

WILLIAM STREET

CHURCHILL BOULEVARD

WILLIAM STREET

WILLIAM STREET

WILLIAM STREET

WILLIAM STREET

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WILLIAM STREET

WILLIAM STREET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12072

12074

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGAN Y</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>11 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>SACRED HEART HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>CHARLES Edward Reynard</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>11 10 1959</b>  |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 9, 1903</b> |
| 9. AGE (In years lost birthday)<br><b>56</b> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Restaurant Prop.</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Edinburgh, Va.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Nathan C. Reynard</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Reeser</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No.</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b> Address <b>Cumberland, Md.</b><br><b>Mr. Charles E. Reynard Jr. 309 Paca St.,</b>                            |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>June 1958</b> to <b>Nov. 10, 1959</b> , that I last saw the deceased alive on <b>Nov. 9, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.   |                                  |  |   |
| ACTUAL SIGNATURE <b>B. M. Schindler</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>43 Green Street</b> DATE SIGNED <b>11/11/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Dr. B.M. Schindler</b>  |                                  | <b>43 Green Street</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11/13/59</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>St. Luke's Cem.</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. Wayne George</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE NOV 16 '59</b>  |   |
| ADDRESS<br><b>Cumberland, Md.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Krawt</b>   |   |

12071

CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12075

Reg. Dist. No.

|  |                                  |   |  |   |   |   |   |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>8 hours</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>La Vale</b>  |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>53 La Vale Blvd</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) <b>JOHN FRANKLIN RICHARDSON</b>  |                                  |   |  | 4. DATE OF DEATH <b>November 12 19 59</b>   |   |   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 17, 1922</b> |   | 9. AGE (In years last birthday)<br><b>37 yrs.</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Production Manager</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>National Jet Co.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Frostburg, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>John V. Richardson</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Lula Michael</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT <b>53 La Vale Blvd. Ida E. Richardson La Vale, Maryland</b>   |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Due to Coronary Sclerosis</b><br>DUE TO (c) <b>Hypertension</b>   |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/> |                                  |   |  |   |   |   |   |
| ACTUAL SIGNATURE <b>Benedict Skitarellic</b>   |                                  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |   |
| EXAMINER'S NAME (Type) <b>Benedict Skitarellic, M.D.</b>   |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
|  |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 12, 1959</b>  |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>Nov. 15, 1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Mem. Park</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Frostburg, Maryland</b>                       |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>NOV 18 '59</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur L. Thomas</b>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12076

Reg. Dist. No.

12108

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Allegany</b></span> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural--Westernport,</b>  |  | c. LENGTH OF STAY IN 1b<br><b>4 yrs.</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-- Westernport</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1/2 mile E. Westernport</b>  |  |  |  | d. STREET ADDRESS<br><b>1/2 Mile E. Westernport</b>   |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print) <b>Robert Clifton Riley</b>   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <b>Nov.</b> Day <b>24</b> Year <b>19 59</b>  |  |  |  |
| <b>5. SEX</b><br><b>Male</b>  |  | <b>6. COLOR OR RACE</b><br><b>White</b>  |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>             |  |  |  |
| <b>8. DATE OF BIRTH</b><br><b>Oct. 10, 1910</b>   |  | <b>9. AGE</b> (In years last birthday)<br><b>49</b> yrs.   |  | <b>IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/><br>Months Days Hours Min.  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Car Inspector</b>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>W. Md. R.R.</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>West Virginia</b>  |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |  |  | <b>13. FATHER'S NAME</b><br><b>Albert Riley</b>   |  |  |  |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Lavena Chaney</b>   |  |  |  | <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)   |  |  |  |
| <b>16. SOCIAL SECURITY NO.</b><br><b>705-10-8391</b>  |  | <b>17. INFORMANT</b> <b>Mary Riley</b> Address <b>Westernport, Md.</b>   |  |   |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction, left; large</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Sclerosis with Thrombosis</b><br>(c), stating the underlying cause lost. DUE TO <b>Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>1 Yr.</b><br><b>recent.</b> |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  |
| <b>20f. (City or town)</b> (County) (State)   |  | <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |   |  |  |  |
| <b>ACTUAL SIGNATURE</b> <b>W. O. McLane</b> <b>M.D.</b>   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |  | <b>DATE SIGNED</b>  |  |  |  |
| <b>EXAMINER'S NAME (Type)</b> <b>W. O. McLane, M.D.</b>   |  | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |  | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>November 24, 1959</b>   |  |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  | <b>22b. DATE THEREOF</b><br><b>11/27/59</b>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Philos</b>  |  |  |  |
| <b>22d. LOCATION (City, town, or county)</b><br><b>Westernport</b>  |  | <b>22e. (State)</b><br><b>Md.</b>  |  |   |  |  |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Boal's Funeral Service</b> <b>Westernport, Md.</b>   |  |  |  | <b>24a. REC'D BY REGISTRAR</b> <b>NOV 25 '59</b>  |  |  |  |
| <b>ADDRESS</b>  |  |  |  | <b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>  |  |  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100



12077

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                  |   |  |  |  |   |  |
|---|------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b>  |                  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> |  | b. COUNTY <b>Allegany</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Luke</b>   |                  | c. LENGTH OF STAY IN 1b<br><b>20 Yrs</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Luke</b>            |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>323 Pratt</b>  |                  |   |  | d. STREET ADDRESS<br><b>323 Pratt</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)  |                  | First Middle Last   |  | 4. DATE OF DEATH   |  | Month Day Year  |  |
| <b>Geraldine</b>  |                  | <b>Druculla Robinson</b>  |  | <b>Nov. 4</b>  |  | <b>1959</b>   |  |
| 5. SEX  | 6. COLOR OR RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)   |  |
| <b>Female</b>   | <b>White</b>     |   |  | <b>April 19, 1910</b>  |  | <b>49 yrs</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| <b>House wife</b>   |                  | <b>Own Home</b>   |  | <b>W. Va.</b>  |  | <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Harley Harvey</b>   |                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ivy White</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                  | 16. SOCIAL SECURITY NO.   |  | INFORMANT  |  | Address   |  |
| <b>no</b>   |                  |   |  | <b>J.R. Robinson-Luke, Md.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Congestive heart Failure.,</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Occlusion</b><br>DUE TO (c) <b>Arteriosclerosis</b> |                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6mo</b><br><b>10 dys.</b><br><b>10 yrs</b>                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                          |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                       |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July</b> 19 <b>59</b> , to <b>Nov 4</b> 19 <b>59</b> that I last saw the deceased alive on <b>Nov 1st</b> 19 <b>59</b> , and that death occurred at <b>Loam</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><i>[Signature]</i>  |                  | M.D. <b>Piedmont W Va</b>   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>James H. Wolverton Sr Md.</b>   |                  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                  | 22b. DATE THEREOF<br><b>11/7/59</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport Md.</b>                           |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E.L. Biral</b>   |                  |   |  | ADDRESS<br><b>Westernport, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 5 59</b>   |  |
|   |                  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 12074 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

12078

Reg. Dist. No.

|   |  |                                    |  |  |  |  |  |
|---|--|------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND   |  |                                    |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>  |  |                                    |  | c. LENGTH OF STAY IN 1b <b>56 yrs.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>322 Cumberland Street</b>   |  |                                    |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Rohman, Jr.</b> Last <b>Rohman, Jr.</b>   |  |                                    |  | 4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>19 59</b>  |  |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>      |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>April 4, 1903</b>                                  |  |
| 9. AGE (In years last birthday) <b>56</b> yrs.  |  | IF UNDER 1 YEAR Months <b>56</b>   |  | IF UNDER 24 HRS. Days <b>56</b> Hours <b>56</b> Min. <b>56</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>   |  |                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Brewing Co.</b>   |  | 11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>       |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |                                    |  |  |  |  |  |
| 13. FATHER'S NAME <b>Martin Rohman, Sr.</b>   |  |                                    |  | 14. MOTHER'S MAIDEN NAME <b>Barbara Myers</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>  |  |                                    |  | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)   |  | 17. INFORMANT Address <b>Mrs. Martin Rohman, Cumberland, Md.</b>       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b><br>DUE TO <b>420.0</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b><br>DUE TO (c) <b>Artero Sclerotic Heart Disease</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                    |  |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b><br><b>3 days</b><br><b>5 years</b>  |  |                                    |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                    |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                    |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |                                    |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |                                    |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>Nov. 2</b> , <b>1959</b> , to <b>Nov. 2</b> , <b>1959</b> , that I last saw the deceased alive on <b>Nov. 2</b> , <b>1959</b> , and that death occurred at <b>6:30</b> P. M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>126 N. Smallwood St.</b> DATE SIGNED<br>ACTUAL SIGNATURE <b>Louis M. Glick</b> M.D. <b>Cumberland, Maryland</b><br>PHYSICIAN'S NAME (Type) <b>Louis M. Glick, M.D.</b>                   |  |                                    |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 22b. DATE THEREOF <b>11-5-1959</b> |  | 22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>   |  |                                    |  | 24a. REC'D BY REGISTRAR DATE <b>NOV 6 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>                      |  |



12095

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg, Maryland</b>   |                               | c. LENGTH OF STAY IN 1b<br><b>3 weeks</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Mt. Savage, Maryland</b>  |   |
|  |                               | f. STREET ADDRESS  |   |
|  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <b>James</b> <b>Lewis</b> <b>Rolfe</b>   |                               | 4. DATE OF DEATH <b>Nov.</b> <b>12,</b> <b>19</b> <b>59</b>  |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>August 28, 1881</b> |
| 9. AGE (In years last birthday) <b>78</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Brick yard employee</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Brickmaking</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Eston, Yorkshire, England</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   |
| 13. FATHER'S NAME<br><b>George Rolfe</b>   |                               | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Fox</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>215-10-1208</b>   |   |
| 17. INFORMANT <b>Mrs. James L. Rolfe</b>   |                               | Address <b>Mt. Savage, Maryland</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>292.4 Aplastic Anemia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(c) <b>NONE</b> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 yrs.</b><br><b>25 yrs?</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Oct. 19, 56</b> to <b>Nov. 12, 1959</b> , that I last saw the deceased alive on <b>Nov. 12, 1959</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <b>Martin M. Rothstein M.D.</b>   |                               | ADDRESS (Street, city or town, state) <b>48 BROADWAY -</b>   |   |
| PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D.</b>  |                               | DATE SIGNED <b>11/15/59</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>Nov. 16, 1959</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>St. George Episcopal</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>Mt. Savage Allegany Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey S. Leigler</b>  |                               | ADDRESS <b>Hyndman, Pennsylvania</b>   |   |
| 24a. REC'D BY REGISTRAR <b>NOV 17 '59</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Christina E. Kraus</b>   |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

DATE OF DEATH

PLACE OF DEATH

MANNER OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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DATE OF DEATH



12075  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

12080

Reg. Dist. No.

|   |                                  |   |   |   |                                      |  |   |
|---|----------------------------------|---|---|---|--------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> |                                      |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>  |                                  |   |   | c. LENGTH OF STAY IN 1b <b>9 DAYS</b>   |                                      |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b><br><b>MEMORIAL &amp; WARWICK AVES.,</b>   |                                  |   |   | d. STREET ADDRESS <b>700 LAFAYETTE AVE.,</b>  |                                      |  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |   |   |   |                                      |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>Agnes</b> Last <b>RUBY</b>   |                                  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>25</b> Year <b>1959</b>  |   |   |                                      |  |   |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 20 1895</b> | 9. AGE (In years last birthday)<br><b>64</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours | IF UNDER 24 HRS.<br>Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Cook</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Railroad Y.M.C.A.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>PENNA McKeesport</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   |
| 13. FATHER'S NAME<br><b>MICHAEL BEAN</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET E. MC CORMICK</b>   |                                      |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>214-05-6611</b>   |   | INFORMANT Address<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>  |                                      |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b><br><b>443X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Small Stroke Syndromes 1</b><br>DUE TO (c) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> |                                  |   |   |   |                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetic Mellitus</b>  |                                  |   |   |   |                                      |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |                                      |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                      | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Sept 1959</b> to <b>Nov 1959</b> , that I last saw the deceased alive on <b>Nov 25 1959</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.  |                                  |   |   |   |                                      |  |   |
| ACTUAL SIGNATURE <b>[Signature]</b>   |                                  |   |   | ADDRESS (Street, city or town, state) <b>153 Va Ave Cumberland, Md</b>  |                                      |  |   |
| PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>  |                                  |   |   | DATE SIGNED <b>11/25/59</b>   |                                      |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11-30-59</b>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>  |                                      | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>James F. Scarpelli</b>   |                                  |   |   | 24a. REC'D BY REGISTRAR<br><b>NOV 30 '59</b>  |                                      | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kneass</b>                        |   |

CERTIFICATE OF DEATH

1907

ALLGARY

MARYLAND

ALLGARY

CUMBERLAND

9 DAYS

CUMBERLAND

100 LAFAYETTE AVE.

MEMORIAL HOSPITAL  
WASHINGTON AVE.

RUBY

MARY ANN KENNER

JULY 30 1907

WHITE

PENNA. HOSPITAL

MICHAEL BRAY

MARGARET E. MC CORMICK

ST. JOSEPH'S HOSPITAL, CUMBERLAND, MD.

D. OVERTON HINNEMANN

REPORT

DATE

11-11-11

NOV 11

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12081

12076

Item 2 Filing 255 12-5-59 et

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegany</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |  | c. LENGTH OF STAY IN 1b<br><b>1 day</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland Bedford</b>   |  | d. STREET ADDRESS <b>75 X-3</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Sacred Heart Hospital</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | Rt. #3 Lake Gordon  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Van</b> Middle <b>Lear</b> Last <b>Ryan</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>11</b> Day <b>23</b> Year <b>1959</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 8, 1874</b>                                 |  |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>23</b> Hours <b>15</b> Min.                                   |  | IF UNDER 24 HRS.<br>Hours <b>15</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer Ret.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Farm</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>                            |  |
| 13. FATHER'S NAME<br><b>Daniel Ryan</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Robertson</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT Address<br><b>Miss Nora Ryan, Route 3, Bedford, Pa.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardio-vascular disease</b><br>(c), stating the underlying cause lost. DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Hrs.</b>  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>19</b> o. m. <b>19</b> p. m.   |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Benedict Skitaralic</b> M.D.  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>Benedict Skitaralic, M.D.</b>   |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 23, 1959</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>Nov. 25, 1959</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Zion Memorial Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Byron Knight</b>   |  |   |  | ADDRESS<br><b>Cumberland, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 27 '59</b>                       |  |
|   |  |   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>William L. Kline</b>                   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

18681

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18032

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| NAME OF DECEASED<br>JAMES H. HARRIS     |  | AGE<br>35                    |  | SEX<br>Male                              |  | RACE<br>White                                |  |
| DATE OF DEATH<br>April 1, 1922          |  | PLACE OF DEATH<br>Home       |  | CITY<br>Baltimore                        |  | COUNTY<br>Baltimore                          |  |
| OCCUPATION<br>Carpenter                 |  | EDUCATION<br>High School     |  | MARRIAGE<br>Married                      |  | RELIGION<br>Roman Catholic                   |  |
| CAUSE OF DEATH<br>Heart Disease         |  | MANNER OF DEATH<br>Natural   |  | IMMEDIATE CAUSE<br>Myocardial Infarction |  | DISEASE OR INJURY<br>Coronary Artery Disease |  |
| DATE OF EXAMINATION<br>April 1, 1922    |  | PLACE OF EXAMINATION<br>Home |  | CITY<br>Baltimore                        |  | COUNTY<br>Baltimore                          |  |
| NAME OF EXAMINER<br>J. H. HARRIS        |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF WITNESS<br>J. H. HARRIS         |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF SECOND WITNESS<br>J. H. HARRIS  |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF THIRD WITNESS<br>J. H. HARRIS   |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF FOURTH WITNESS<br>J. H. HARRIS  |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF FIFTH WITNESS<br>J. H. HARRIS   |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF SIXTH WITNESS<br>J. H. HARRIS   |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF SEVENTH WITNESS<br>J. H. HARRIS |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF EIGHTH WITNESS<br>J. H. HARRIS  |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF NINTH WITNESS<br>J. H. HARRIS   |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |
| NAME OF TENTH WITNESS<br>J. H. HARRIS   |  | SIGNATURE<br>J. H. HARRIS    |  | DATE<br>April 1, 1922                    |  | PLACE<br>Baltimore                           |  |

## CERTIFICATE OF DEATH

Reg. Dist. No.

12082

12096

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>66 Yrs</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>107 OakView Drive</b>   |                                     | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lulu</b> Middle <b>Allen</b> Last <b>Seckman</b>   |                                     | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>4</b> Year <b>1959</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 17, 1884</b>                                     |
| 9. AGE (In years last birthday)<br><b>74</b> yrs.  |                                     | 10. IF UNDER 1 YEAR<br>Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.   | 11. IF UNDER 24 HRS.<br>Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>West Virginia</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>George W. Raines</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Arnold</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                     | 16. SOCIAL SECURITY NO.<br><b>John Seckman-Westernport, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cordiae Failure with pulmonary Edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis with Cordiae Degeneration</b><br>(c) <b>Not Specified as rheumatic</b> |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Hours</b><br><b>10 Years</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arthritis Deformans</b>   |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>    |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>Nov. 2</b> , 1959, to <b>Nov. 4</b> , 1959, that I last saw the deceased alive on <b>Nov. 3</b> , 1959, and that death occurred at <b>12:45 A.M.</b> from the causes and on the date stated above.  |                                     |   |  |
| ACTUAL SIGNATURE <b>Paul R. Wilson</b>   |                                     | DATE SIGNED <b>11-4-59</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Paul R. Wilson</b>  |                                     | ADDRESS (Street, city or town, state) <b>M.D. 111 Ashfield St. Piedmont, W.Va.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>11/6/59</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport Md.</b>      |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>El. Boal</b>  |                                     | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 9 '59</b>  |  |
| ADDRESS<br><b>Westernport, Md.</b>   |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2205

[illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6252 11/18/59

12077

CERTIFICATE OF DEATH

12083

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>7yrs.4mo.15da.</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sylvan Retreat</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anna</b> Middle <b>May</b> Last <b>Shuckhart</b>  |                                  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>10</b> Year <b>19 59</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH<br><b>3-16-59 1882</b> |
| 9. AGE (In years last birthday)<br><b>77</b> yrs.   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>John Shuckhart</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ellen Porter</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Mrs. Charles Lessiter, 1190 South Avenue</b>  |                                  | Address <b>Barberton, Ohio.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422 Chronic Myocardial Degeneration</b><br>DUE TO <b>450 General arteriosclerosis</b><br>DUE TO <b>592 Chronic Nephritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>325 Mental Deficiency</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b><br><b>?</b><br><b>?</b>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Jan. 22, 1952</b> to <b>Nov. 10, 1959</b> , that I last saw the deceased alive on <b>Nov. 9, 1959</b> , and that death occurred at <b>2:34 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |                                  |   |   |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.  |                                  | DATE SIGNED   |   |
| PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>  |                                  | <b>49 Greene St., Cumberland, Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/12/59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Frostburg Memorial Park, Frostburg, Md.</b>  |                                  | 22d. LOCATION (City, town, or county) (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Reuben H. Montemur</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>Nov 16 '59</b>  |   |
| ADDRESS<br><b>23 East Main, Frostburg, Md.</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Evans</b>  |   |

CERTIFICATE OF DEATH

|                  |  |                |  |                |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |                        |  |
|------------------|--|----------------|--|----------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased |  | Sex            |  | Age            |  | Date of Birth          |  | Place of Birth         |  | Usual Residence        |  | Cause of Death         |  | Date of Death          |  | Time of Death          |  | Place of Death         |  | Signature of Physician |  | Signature of Registrar |  |
| John Doe         |  | Male           |  | 45             |  | 1910                   |  | Maryland               |  | Baltimore              |  | Heart Disease          |  | 1955                   |  | 10:00 AM               |  | Home                   |  | Dr. Smith              |  | J. Doe                 |  |
| Occupation       |  | Marital Status |  | Education      |  | Religion               |  | Race                   |  | Color                  |  | Manner of Death        |  | Certified by           |  | Date                   |  | Signature              |  | Signature              |  | Signature              |  |
| Teacher          |  | Married        |  | High School    |  | Catholic               |  | White                  |  | White                  |  | Natural                |  | Physician              |  | 1955                   |  | J. Doe                 |  | J. Doe                 |  | J. Doe                 |  |
| Date of Death    |  | Time of Death  |  | Place of Death |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  | Signature of Registrar |  | Signature of Physician |  |
| 1955             |  | 10:00 AM       |  | Home           |  | Dr. Smith              |  | J. Doe                 |  | Dr. Smith              |  | J. Doe                 |  | Dr. Smith              |  | J. Doe                 |  | Dr. Smith              |  | J. Doe                 |  | Dr. Smith              |  |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12084

Reg. Dist. No.

12078

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b><br>c. LENGTH OF STAY IN lb <b>2 Hrs.</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART</b>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b><br>d. STREET ADDRESS <b>71 MAPLE AVE.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>MARY</b> Middle <b>Panetta</b> Last <b>SPANO</b>   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>11</b> Day <b>18</b> Year <b>1959</b>  |  |  |  |   |  |
| <b>5. SEX</b><br><b>FEMALE</b>  |  | <b>6. COLOR OR RACE</b><br><b>WHITE</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>  |  | <b>8. DATE OF BIRTH</b><br><b>June, 20, 1910</b>                                 |  | <b>9. AGE</b> (In years last birthday) <b>49</b> yrs.<br>IF UNDER 1 YEAR: Months <b>4</b> Days <b>28</b><br>IF UNDER 24 HRS.: Hours <b>4</b> Min. <b>28</b> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Keyser, W. Va.</b>        |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |  |
| <b>13. FATHER'S NAME</b><br><b>Frank Panetta</b>  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Katherine Comisso</b>  |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service)<br><b>No</b>   |  | <b>16. SOCIAL SECURITY NO.</b><br><b>None</b>   |  | <b>17. INFORMANT</b><br><b>Nicola Spano, 71 Maple Ave. Keyser, W. Va.</b>  |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b><br>DUE TO <b>Skull Fracture</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>812x</b><br>(c) <b>Struck by Automobile</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1:05 Hrs.</b><br><b>1:05 Hrs.</b>  |  |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/><br><b>CAUSE OF DEATH.</b>  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>Struck by Automobile</b>   |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br><b>3:00 p. m. Nov. 18 1959</b>   |  | <b>20d. INJURY OCCURRED</b><br>While <input type="checkbox"/> Not while <input checked="" type="checkbox"/><br>of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>Street</b>   |  | <b>20f. (City or town)</b> <b>Cumberland, Alleg.</b> (County) (State) <b>Md.</b> |  |   |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> |  |   |  |  |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <i>Benedict Skitarellic</i> <b>M.D.</b><br><b>EXAMINER'S NAME (Type)</b> <b>Benedict Skitarellic, M.D.</b>  |  |   |  | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>Nov. 18, 1959</b>  |  |  |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  | <b>22b. DATE THEREOF</b><br><b>11-21-59</b>   |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>St. Thomas Cem.</b>  |  | <b>22d. LOCATION (City, town, or county)</b> <b>Keyser W. Va.</b> (State)        |  |   |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><i>Thomas Smith Jr. Keyser, W. Va.</i>   |  |   |  | <b>24a. REC'D BY REGISTRAR</b><br><b>NOV 20 '59</b>  |  | <b>24b. REGISTRAR'S SIGNATURE</b><br><i>Arthur L. Hines</i>                      |  |   |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12085

12079

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Allegany</u> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>  |                                   | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>317 Greene St.</u>  |                                   | d. STREET ADDRESS <u>317 Greene St.</u>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |  |   |
| 3. NAME OF DECEASED (Type or print) <u>Wilhelmina</u> First <u>Steppe</u> Middle <u>Steppe</u> Last   |                                   | 4. DATE OF DEATH <u>Nov. 9</u> Month <u>9</u> Day <u>19</u> Year <u>59</u>   |   |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>     | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 11 1891</u>                           |
| 9. AGE (In years last birthday) <u>68</u> yrs.  |                                   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |   |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Barrett Indiana</u>  |                                   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>Henry T. Hartung</u>   |                                   | 14. MOTHER'S MAIDEN NAME <u>Christine Zeigler</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service)   |                                   | 16. SOCIAL SECURITY NO. <u>Miss Rhea Griffin</u> Address <u>Cumb. Md</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u><br>154X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus; Arteriosclerotic Heart Disease</u> |                                   | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>11/1/59</u> , 19 <u>57</u> , to <u>1959</u> , that I last saw the deceased alive on <u>9 Nov</u> , 19 <u>59</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>59 GREENE ST</u> DATE SIGNED <u>11/10/59</u>   |                                   |  |   |
| ACTUAL SIGNATURE <u>S. G. Wersman</u> M.D.  |                                   |  |   |
| PHYSICIAN'S NAME (Type) <u>S. G. Wersman</u>  |                                   | <u>COMBERLAND MARYLAND</u>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>11/11/59</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>   | 22d. LOCATION (City, town, or county) (State) <u>Cumb. Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u>  |                                   | 24a. REC'D BY REGISTRAR DATE <u>NOV 12 '59</u>   |   |
|   |                                   | 24b. REGISTRAR'S SIGNATURE <u>Christina S. Knepp</u>   |   |



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

12837

12075

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>HOME                  |  | 2. NAME OF DECEASED<br>JOHN J. SMITH          |  |
| 3. SEX OF DECEASED<br>MALE                 |  | 4. AGE OF DECEASED<br>65                      |  |
| 5. RACE OF DECEASED<br>WHITE               |  | 6. DATE OF DEATH<br>JAN 15 1968               |  |
| 7. TIME OF DEATH<br>10:30 AM               |  | 8. CAUSE OF DEATH<br>HEART DISEASE            |  |
| 9. PLACE OF BIRTH<br>BALTIMORE, MD         |  | 10. DATE OF BIRTH<br>JAN 15 1903              |  |
| 11. OCCUPATION<br>CLERK                    |  | 12. MARITAL STATUS<br>MARRIED                 |  |
| 13. PREVIOUS ILLNESS<br>NONE               |  | 14. SIGNATURE OF PHYSICIAN<br>DR. J. H. SMITH |  |
| 15. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 16. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 17. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 18. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 19. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 20. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 21. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 22. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 23. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 24. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 25. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 26. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 27. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 28. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 29. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 30. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 31. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 32. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 33. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 34. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 35. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 36. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 37. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 38. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 39. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 40. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 41. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 42. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 43. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 44. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 45. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 46. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 47. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 48. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 49. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 50. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 51. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 52. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 53. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 54. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 55. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 56. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 57. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 58. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 59. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 60. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 61. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 62. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 63. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 64. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 65. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 66. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 67. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 68. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 69. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 70. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 71. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 72. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 73. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 74. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 75. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 76. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 77. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 78. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 79. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 80. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 81. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 82. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 83. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 84. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 85. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 86. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 87. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 88. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 89. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 90. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 91. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 92. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 93. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 94. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 95. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 96. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 97. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 98. SIGNATURE OF WITNESS<br>JOHN J. SMITH     |  |
| 99. SIGNATURE OF DECEASED<br>JOHN J. SMITH |  | 100. SIGNATURE OF WITNESS<br>JOHN J. SMITH    |  |

12075

12075



## CERTIFICATE OF DEATH

Reg. Dist. No.

12086

12097

|   |                                  |   |  |  |  |   |   |
|---|----------------------------------|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Westernport</b>  |                                  | c. LENGTH OF STAY IN lb<br><b>4 Yrs</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>43 Westernport</b>                              |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Kooken Nursing Home</b>  |                                  |   |  | d. STREET ADDRESS<br><b>115 Main</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lucinda</b> Middle <b>True</b> Last <b>True</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>Nov.</b> Day <b>8</b> Year <b>19 59</b>   |  |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept. 2, 1882</b>   |  | 9. AGE (In years last birthday)<br><b>77</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House-wife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>West Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>William Hanlin</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Murphy</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b>   |  | Address<br><b>Mrs. Frank Saleskey-Westernport, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>331X Cerebral Hemorrhage</b><br>DUE TO (b) <b>Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>13 Days</b><br><b>2 Years</b>                              |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |  |  |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>October 23, 1959</b> , to <b>Nov. 8, 1959</b> , that I last saw the deceased alive on <b>Nov. 8, 1959</b> , and that death occurred at <b>5:40 p.m.</b> , from the causes and on the date stated above.  |                                  |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>Paul R. Wilson</b>   |                                  |   |  | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>111 Ashfield St. Piedmont, W. Va. 11-10-59</b>                                 |  |   |   |
| PHYSICIAN'S NAME (Type)<br><b>Paul R. Wilson M.D.</b>   |                                  |   |  |  |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11/11/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Nethken Hill Cem</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Elk Garden W. Va.</b>                         |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. L. Boral</b>  |                                  | ADDRESS<br><b>Westernport, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 12 '59</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hump</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12088

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1908

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1907

ALBANY:

THE STATE PRINTING OFFICE

1908

100

100

100

100

100

100



CERTIFICATE OF DEATH

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1908

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

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REPORT

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COMMISSIONERS

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IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

APRIL 1, 1907

ALBANY:

THE STATE PRINTING OFFICE

1908

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G254 12-31-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

12080

12087

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>     |  |  |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Memorial Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>CARL CLINTON WAGNER</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>November</b> Day <b>28</b> Year <b>19 59</b>  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>August 13, 1899</b>   |  |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>60</b> Days <b>28</b> Hours <b>19</b> Min. <b>59</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O Railroad</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Maryland</b>                                  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>J. George Wagner</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Zita Catherine Lydinger</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>                           |  | 16. SOCIAL SECURITY NO.<br><b>705-05-4607</b>  |  | 17. INFORMANT<br><b>Mrs. Marie Lange Wagner</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>420.1 DUE TO <b>Coronary Artery Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>2 yrs</b><br>(c) <b>2 yrs</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Unlabeled</b>   |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b>19</b>   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>122 S. Centre Street</b>  |  | 20f. (City or town) (County) (State)<br><b>Cumberland, Maryland</b>  |  | 21. I certify that I attended the deceased from <b>April 4, 1957</b> , to <b>November 28, 1959</b> , that I last saw the deceased alive on <b>November 28, 1959</b> , and that death occurred at <b>4:30 P.</b> M, from the causes and on the date stated above.   |  |
| 21. ACTUAL SIGNATURE<br><b>Richard J. Williams</b>  |  | 21. ADDRESS (Street, city or town, state)<br><b>122 S. Centre Street</b>   |  | 21. DATE SIGNED<br><b>11/30/59</b>   |  | 21. PHYSICIAN'S NAME (Type)<br><b>Richard Williams M.D.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>12/1/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Hillcrest Burial Park</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John J. Hafer, Cumberland, Maryland</b>                            |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 4 '59</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. House</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12050

11

Allegany

Allegany

Cambridge

Cambridge

Medical Director

300 Woodside Avenue

CARL

CLINTON

WALTER

November 28

Male White

August 13, 1950

Resident

1000 1/2 Railroad

Cambridge, Maryland

J. George Wagner

Miss Catherine Lydinger

705-02-4807 MR. Louis George Wagner Cambridge, Maryland  
300 Woodside Ave.

*Handwritten signatures and notes, including "George Wagner" and "Miss Catherine Lydinger".*

Richard Williams

M.D.

102 St. Centre St. Cambridge, Maryland

John A. Hater

Misses Wright Park

Cambridge, Maryland

John A. Hater, Cambridge, Maryland

CERTIFICATE OF DEATH

12081

12088

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>79 Green St.</b> b. COUNTY <b>Allegany</b> <b>Cumberland</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>02 Cumberland // Md. FLINTSTONE</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Sacred Heart Hospital</b>  |                                  | d. STREET ADDRESS<br><b>1 79 Green St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>                                    |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mahulda</b> Middle <b>Weight</b> Last <b>Weight</b>   |                                  | 4. DATE OF DEATH<br>Month <b>11/20</b> , -59 Day <b>159</b> Year <b>159</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>10/1, -1879 1870</b> |
| 9. AGE (In years last birthday)<br><b>89</b> yrs.   |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Aron Potts</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Not Known</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| INFORMANT<br><b>Daughter in law.</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br><b>493X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>                                   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>11/6</b> , 19 <b>59</b> , to <b>11/20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/20</b> , 19 <b>59</b> , and that death occurred at <b>4:18 P.M.</b> from the causes and on the date stated above.                       |                                  |   |   |
| ACTUAL SIGNATURE<br><b>Dr. Leo Ley.</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>456 N. Center St. Cumberland, Md.</b>   |   |
| PHYSICIAN'S NAME (Type)<br><b>Dr. Leo Ley.</b>  |                                  | DATE SIGNED<br><b>11/21/59</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>11.23.59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Christian</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Artumas Bedford Penna.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard J. Stone</b>  |                                  | ADDRESS<br><b>Hancock Md</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>NOV 27 '59</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Frank</b>  |   |

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

• *Ref. 11 continued*



## CERTIFICATE OF DEATH

Reg. Dist. No.

12089

12082

|  |                                  |  |                                       |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>  |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>24 DAYS</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>MEMORIAL HOSPITAL<br/>MEMORIAL &amp; WARWICK AVES.,</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RICHARD</b> Middle <b>N.</b> Last <b>WILSON</b>  |                                  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>26</b> Year <b>1959</b>   |                                       |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>DECEMBER 1</b> |
| 9. AGE (In years last birthday)<br><b>85</b> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>5</b> Hours <b>15</b> Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>COAL MINER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>COAL MINES</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                       |
| 13. FATHER'S NAME<br><b>BENJAMIN WILSON</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>RACHEL WEIMER</b>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br><b>INFORMANT</b><br><b>MEMORIAL HOSPITAL</b>  |                                       |
| 17. ADDRESS<br><b>CUMBERLAND, MD.</b>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) <b>Epistaxis &amp; Severe Hemorrhage</b> |                                       |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20a. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>11/24</b> 19 <b>59</b>   |                                  | 20b. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/>   |                                       |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20d. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <b>11/12</b> , 19 <b>59</b> , to <b>11/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>11/24</b> , 19 <b>59</b> , and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above. |                                  | 22. ADDRESS (Street, city or town, state) DATE SIGNED<br><b>59 GREENE ST</b> <b>12/1/59</b>  |                                       |
| ACTUAL SIGNATURE <b>A. Wersman</b> M.D.  |                                  | PHYSICIAN'S NAME (Type) <b>S. G. Wersman MD Cumberland Maryland</b>  |                                       |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSITION<br><b>XXXX XXXXXX</b>   |                                  | 22b. DATE THEREOF<br><b>11-29-59</b>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>FROSTBURG MEMORIAL PARK,</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>FROSTBURG, MARYLAND</b>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. R. Durst</b>   |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 3 '59</b>   |                                       |
| ADDRESS<br><b>Frostburg, Md.</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hume</b>  |                                       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12083

CERTIFICATE OF DEATH

Reg. Dist. No.

12090

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CUMBERLAND,</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 HOURS</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give place of death)<br><b>MEMORIAL HOSPITAL</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BABY</b> Middle <b>BOY</b> Last <b>WOLFE</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>NOVEMBER</b> Day <b>24</b> Year <b>1959</b>   |  |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>NOVEMBER 24 '59</b>                                   |  |
| 9. AGE (In years lost birthday) yrs.  |  | 10. IF UNDER 1 YEAR Months  |  | 11. IF UNDER 24 HRS. Days  |  | 12. IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>CUMBERLAND, MARYLAND</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  |  |
| 13. FATHER'S NAME<br><b>CHARLES F. WOLFE</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>CAROLE SCHENADEK SchoenadeL</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.  |  |  |  |
| 17. INFORMANT<br><b>MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND</b>   |  |   |  | Address  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Amnionia (Intra uterine)</b><br>761.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Premature Separation Placenta</b><br>DUE TO (c) |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>8:20PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Fuller B Whitworth</b> M.D.   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>DR. FULLER WHITWORTH</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |  | 22b. DATE THEREOF<br><b>11-26-59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Hospital</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Cumberland, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE  |  |   |  | ADDRESS  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>DEC 1 '59</b>                             |  |
|   |  |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Hines</b>                         |  |

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CERTIFICATE OF DEATH

15003



ALLERANY MARYLAND

CUMBERLAND

MEMORIAL HOSPITAL  
WOMEN & MEN  
W.C.

NOVEMBER 29, 1944

WHITE

CUMBERLAND, MARYLAND

CHARLES F. WOLF  
CAROLE GOLDBERG  
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND



DR. ELLER WHITMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12091

12098

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                   |  |   |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>ALLEGANY</b> MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>   |                                   | c. LENGTH OF STAY IN 1b <b>4 DAYS</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MINERS HOSPITAL</b>   |                                   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>(REPHANN)</b> Last <b>WOLFORD</b>   |                                   | 4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>14</b> , Year <b>19 59</b>   |   |
| 5. SEX <b>FEMALE</b>  | 6. COLOR OR RACE <b>WHITE</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>APRIL 25, 1877</b>                            |
| 9. AGE (In years last birthday) <b>82</b> yrs.  |                                   | 10. IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |                                   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>HENRY REPHANN</b>  |                                   | 14. MOTHER'S MAIDEN NAME <b>MARY LIDINGER</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                                   | 16. SOCIAL SECURITY NO. <b>NONE</b>  |   |
| 17. INFORMANT <b>ARVEL WOLFORD, ECKHART, MD.</b>  |                                   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b><br>157x DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b> |                                   | INTERVAL BETWEEN ONSET AND DEATH <b>6 mos 22</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>   |                                   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>AUG. 6, 1959</b> , to <b>NOV. 14, 1959</b> , that I last saw the deceased alive on <b>NOV. 14, 1959</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.   |                                   |  |   |
| ACTUAL SIGNATURE <b>Martin Rothstein, M.D.</b>  |                                   | ADDRESS (Street, city or town, state) <b>BROADWAY</b>  |   |
| PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>  |                                   | <b>FROSTBURG, MD.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 22b. DATE THEREOF <b>11-17-59</b> | 22c. NAME OF CEMETERY OR CREMATORY <b>PORTER CEMETERY</b>  | 22d. LOCATION (City, town, or county) (State) <b>ECKHART, MD.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. DURST,</b>  |                                   | ADDRESS <b>FROSTBURG, MD.</b>  |   |
| 24a. REC'D BY REGISTRAR <b>NOV 18 '59</b>   |                                   | 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>  |   |

12098

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

12092

Reg. Dist. No.

12084

|  |                               |  |   |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Allegany</b> <b>MARYLAND</b>   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>   |                               | c. LENGTH OF STAY IN 1b <b>25yrs.3mo.22das.</b> <b>x</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Frostburg</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sylvan Retreat</b>   |                               | d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) First <b>Phillip</b> Middle <b>Buck</b> Last <b>Yeider</b>   |                               | 4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>19 59</b>   |   |
| 5. SEX <b>Male</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH <b>Feb. 2, 1891</b>                                    |
| 9. AGE (In years last birthday) <b>68</b> yrs.   |                               | IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>   | IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>   |   |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |   |
| 13. FATHER'S NAME <b>George Yeider</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Sara Middleton</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>None</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT <b>Nellie Krapf</b> Address <b>106 W. Main, Frostburg, Md.</b>   |                               |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422 Chronic Myocardial Degeneration</b><br><b>592x</b> DUE TO (b) <b>196 Malignant neoplasm of lower jaw</b> <b>3 yrs.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>392 Chronic Nephritis</b> <b>&gt;</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>325 Mental Deficiency</b><br>INTERVAL BETWEEN ONSET AND DEATH <b>?</b> |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b></b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>           |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Jan. 2, 1953</b> to <b>Nov. 17, 1959</b> , that I last saw the deceased alive on <b>Nov. 16, 1959</b> , and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above.   |                               |  |   |
| ACTUAL SIGNATURE <b>James E. McLean</b> M.D.   |                               | ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>11/18/59</b>   |   |
| PHYSICIAN'S NAME (Type) <b>James E. McLean, M.D.</b>   |                               | <b>49 Greene St., Cumberland, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>11/19/59</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>B.H. Montisaut</b> ADDRESS <b>Hafer Funeral Home 23 E. Main, Frostburg, Md.</b>  |                               | 24a. REC'D BY REGISTRAR <b>NOV 24 '59</b>  |   |
| 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>   |                               |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12093

12085

Reg. Dist. No.

|  |   |  |   |  |   |   |   |
|--|---|--|---|--|---|---|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>  |   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cumberland</b>  |   |  | c. LENGTH OF STAY IN 1b<br><b>DOA</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Ooa Oldtown Rd. #1</b>                                    |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Memorial Hospital DOA</b>   |   |  |   | d. STREET ADDRESS<br><b>Rd#1</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <b>Martha</b> Middle <b>Ellen</b> Last <b>Yonker</b>   |   |  |   | <b>4. DATE OF DEATH</b><br>Month <b>Nov.</b> Day <b>23</b> Year <b>19 59</b>   |   |   |   |
| <b>5. SEX</b><br><b>Female</b>   | <b>6. COLOR OR RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><b>May 11, 1883</b>  |  | <b>9. AGE</b> (In years last birthday)<br><b>76</b> yrs.                            | <b>IF UNDER 1 YEAR</b><br>Months      Days      Hours      Min.                                   | <b>IF UNDER 24 HRS.</b><br>Hours      Min.        |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>Own Home</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Rawlings, Maryland</b>       |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>USA</b> |
| <b>13. FATHER'S NAME</b><br><b>Roland Ravenscraft</b>  |   |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Martha Ellen McGowan</b>   |   |   |   |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unknown) <b>no</b>   |   | <b>16. SOCIAL SECURITY NO.</b><br><b>none</b>  |   | <b>17. INFORMANT</b><br><b>Francis Yonker</b> Rt. 1      Address <b>Oldtown, Maryland</b>  |   |   |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Sclerosis</b><br>DUE TO (c) <b>***--</b>  |   |  |   |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |   |  |   |   |   |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>   |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) |  |   |   |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour      o. m.      p. m.      19  |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)                       |  | <b>20f. (City or town)</b> (County)      (State)                                    |   |   |
| <b>21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b> |   |  |   |  |   |   |   |
| <b>ACTUAL SIGNATURE</b> <i>B. Skitaralic</i> M.D.  |   |  |   | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |   | <b>DATE SIGNED</b>  |   |
| <b>EXAMINER'S NAME (Type)</b> <b>B. Skitaralic, M.D.</b>   |   |  |   | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |   | <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>                                |   |
| <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |   | <b>22b. DATE THEREOF</b><br><b>11/25/59</b>  | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><b>Hillcrest Burial Park</b>                           |  | <b>22d. LOCATION (City, town, or county)</b> (State)<br><b>Cumberland, Maryland</b> |   |   |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><b>John J. Hafer, Cumberland, Maryland</b>  |   |  |   | <b>24a. REC'D BY REGISTRAR</b><br><b>NOV 30 '59</b>  |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><i>Arthur S. Kraus</i>                                       |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |  |   |  |
|---|--|---|--|
| <p>NAME OF DECEASED<br/>JAMES J. HARRIS</p> |  | <p>AGE<br/>45</p>                         |  |
| <p>SEX<br/>Male</p>                         |  | <p>DATE OF BIRTH<br/>May 11, 1887</p>     |  |
| <p>PLACE OF BIRTH<br/>Boston, Mass.</p>     |  | <p>DATE OF DEATH<br/>May 11, 1887</p>     |  |
| <p>CAUSE OF DEATH<br/>Diphtheria</p>        |  | <p>PLACE OF DEATH<br/>Boston, Mass.</p>   |  |
| <p>DATE OF EXAMINATION<br/>May 11, 1887</p> |  | <p>TIME OF EXAMINATION<br/>10:30 A.M.</p> |  |
| <p>NAME OF EXAMINER<br/>J. J. HARRIS</p>    |  | <p>ADDRESS<br/>Boston, Mass.</p>          |  |
| <p>SIGNATURE OF EXAMINER</p>                |  | <p>DATE</p>                               |  |

12099

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |  |   |   |   |   |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Allegany</b> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md</b> b. COUNTY <b>Allegany</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Frostburg</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>20 days</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>43 Westernport</b>                             |   |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Miners Hospital</b>   |                                  |   |  | d. STREET ADDRESS<br><b>291 Main St. Ext.</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Grace Zais</b>   |                                  |   |  | 4. DATE OF DEATH Month Day Year<br><b>Nov. 16 1959</b>  |   |   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 3, 1888</b> |   | 9. AGE (In years last birthday) yrs.<br><b>71</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>David Macfarlane</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Isabelle Schuyler</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.   |  | INFORMANT<br><b>Adam Zais -Westernport, Md.</b>   |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>609X Uremia</b><br>DUE TO <b>Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Chronic Urinary infection</b><br>DUE TO (c) <b>Diabetes mellitus</b>                                 |                                  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b><br><b>3 weeks</b><br><b>several years</b>       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Diabetes mellitus</b>  |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br>19   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Oct 27</b> , 19 <b>59</b> , to <b>Nov. 16</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Nov. 12</b> , 19 <b>59</b> , and that death occurred at <b>6:55 P.</b> M. from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>William W. Lesh M.D. 84 Main St. Westernport, Md. 11-17-59</b> |                                  |   |  |   |   |   |   |
| ACTUAL SIGNATURE <b>William W. Lesh M.D.</b>   |                                  |   |  |   |   |   |   |
| PHYSICIAN'S NAME (Type) <b>William W. Lesh, M. D.</b>  |                                  |   |  |   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>11/18/59</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Philos</b>   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Westernport Md.</b>                           |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>E. Boal</b>   |                                  |   |  | ADDRESS<br><b>Westernport, Md.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>NOV 18 '59</b>   |   |
|  |                                  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur S. Kraus</b>  |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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